2004

What Really Matters: Opening Keynote, International Society for Ayurveda and Health, June 2004

Peter J. Deckers
University of Connecticut Health Center

Opening Keynote, June 4th 2004

What Really Matters

Peter J. Deckers, M.D.,
Executive Vice President for Health Affairs, the University of Connecticut Health Center (UCHC), Connecticut, USA

During the past decade I have had the privilege of being the dean of a school of medicine, specifically the University of Connecticut School of Medicine. During the last five years that position has been integrated with that of Executive Vice President of our Health Center. From these vantage points, the enormous changes that have occurred in the delivery of healthcare, the conduct of biomedical research and the education of the physicians and dentists of tomorrow have been especially evident and present to me on virtually a daily basis.

That said, I was the product of an era in medicine in which phenomenal progress in healthcare delivery, in biomedical and behavioral science, in the education of health professionals, and in service to the community was achieved. Unfortunately, the intense focus we placed on hospital-based research, hospital-based training, hospital-based care, combined with proliferating technology and pharmaceuticals, resulted in an exceptionally expensive system that also had significant, unexposed flaws and inequities in safety, quality, cost and access.

As we all know, the past decade witnessed an intense effort by the private business sector and the federal government to at least contain, if not significantly reduce, the cost of healthcare.

The federal government's reform efforts failed. The reasons included:

Complexity of Solutions	Public Desire for Incremental Change
Extensive Governmental Control	Inability to Gain Political Consensus

That did not stop the private sector from continuing their market-driven reform efforts via so called managed care strategies which, when all was said and done, infrequently managed care but did usually aggressively attempt to manage cost. All of us are aware of the dramatic consequences for the health system as we knew it. They included decreased hospitalization, decreased length of stay, decreased specialty services and, most importantly, decreased provider revenues for both hospitals as well as physicians and dentists. Moreover, our efforts to cause the public to be sympathetic to reduced reimbursements for us, and the very real, added hassle of increased administrative and regulatory burdens visited upon each of us as practitioners, have been very unsuccessful. Indeed, the special trust that has always existed between the patient and their health professional has been damaged by all this and by headlines that focus on issues related to medical errors, lapses in medical record security, and major problems in the conduct of clinical research and clinical trials.

Many have looked upon the last decade and the phenomenal change required as " the worst of times, a season of darkness." Although there were moments when I wondered, I don't really see it that way. I think the change required has been exceptionally beneficial. For instance:

- What's wrong with reducing hospital length of stay and hospital admissions?
- What's wrong with minimizing unnecessary tests?
- What's wrong with the careful, prudent use of technology?
- What's wrong with adherence to practice management guidelines and active multidisciplinary case management?
- What's wrong with evidence-based medicine and efficient practice patterns?
- What's wrong with emphasis on the outpatient setting?
- What's wrong with bench marking, outcome analyses and accountability?
- What's wrong with systems designed for quality care, patient safety and disease prevention?
- What is wrong with "doing it right the first time"?

Yes, all of this will lead to a new health care system of the 21st century! Systemic change will occur! But change is always a problem. Machiavelli may have said it best: "There is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful of success, than to step up as a leader in the introduction of change. For he who innovates will have for his enemies all those who are well off under the existing order of things, and only lukewarm supporters in those who might be better off under the new."

Additionally, all of these pressures and changes, again whether we like them or not, demand a new way of educating medical and dental students and residents so that they are effective, efficient, timely and relevant practitioners in the 21st century. Such change also demands new approaches to maintaining our competence over the longer term. My core thesis tonight is that highly skilled, intelligent, motivated people, from many professions working collaboratively, are critical and essential if educational transformation and the enhancement of quality care provided by our health care system is to be successful.

Also, in an effective new health care system, a significant strengthening of those virtues that undergird the doctor/patient relationship and that sustain our professions as a moral enterprise is demanded. Let's briefly explore some of this in the context of undergraduate, graduate education and modern continuing education of physicians and dentists. Medical and Dental Education occur across a continuum that begins with medical and dental school (4 years), progresses for some through residency training (3-8+ years), and continues throughout the career of the practitioner physician (30+ years). I believe the educational programs of both medical and dental schools should target each of these stages of the continuum. In the past these stages were, for the most part, treated as discrete entities. There is now a growing realization that these stages must be better integrated in order to accomplish the overall goal, which is to have a physician workforce that at a minimum,continuously maintains competency and the highest standards of medical professionalism. To this end a number of national organizations are proposing that each stage of the medical education continuum develop educational programs and activities that target the following "core competencies":

- Patient care that is compassionate, appropriate, and effective for the treatment of disease and the promotion of health. SKILLS
- Knowledge about established and evolving biomedical, clinical and epidemiological and social-behavioral sciences and the application of this knowledge to patient care. KNOWLEDGE
- The ability to investigate and evaluate our patient care practices, appraise and assimilate scientific evidence, and improve our patient care practices. PRACTICE-BASED LEARNING
- Interpersonal and communication skills that result in effective information exchange with our patients, their families and our professional associates. COMMUNICATION
- A commitment to carrying out professional responsibilities and adherence to ethical principles. Key is empathy and respect for others, including sensitivity to any differences which create the richness characteristic of our diverse society. PROFESSIONALISM
- Finally, an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. SYSTEMS-BASED PRACTICE

We must create these six competencies in our students in a manner sufficient to allow these new physicians to be successful in GME programs, and we must provide them with the desire and skills necessary to continuously update these competencies over the lifetime of their careers.

Now, let's return to quality as an issue. Witness that the 1999 Institute of Medicine study found that between 44,000 and 98,000 Americans die in hospitals each year due to medical errors. This death rate exceeds motor vehicle crashes, breast cancer and AIDS. The study estimated that beyond the costs in lives, hospital medical errors cost the US economy between $17 and $29 billion/year. More recent studies suggest these numbers may be conservative.

Medical errors include adverse drug events, improper and unnecessary transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries, hospital-acquired infections, falls, burns, pressure ulcers, and mistaken patient identities or, in short, doing too much, too little, or doing it incorrectly!!

One of the recommendations of the IOM Report on Preventable Errors is especially pertinent for surgeons, specifically that regular re-certification include not only traditional knowledge assessment, but also analysis of problem solving, decision-making and practical surgical skills – a re-certification exam similar to that required of airline pilots and conducted in simulators. I believe this type of competency testing will be realized before the end of this decade.

But fundamentally, at a very personal level, the maintenance of competence of a physician or a dentist requires several things—They are:

- Self assessment by the individual of his/her areas of strength and weakness (knowledge, skills, etc.)
- Participation in a targeted, rigorous educational activity and
- Quantitative and qualitative assessment of the impact of the educational activity on one's practice (practice-based learning).

Much of this results from, and requires, "self direction." It is also clear that the best results occur when the educational intervention occurs "just in time" (i.e., at the time, or preferably just before the time, the physician encounters a situation where he/she lacks adequate knowledge or skills to carry out the required task). Information technology can facilitate "just in time" learning, and will undoubtedly replace, across the full educational continuum, the traditional lecture-based CME activity such as what I am doing with you today.

Now knowledge and skills, while critically important, are only but two of the attributes of a true medical professional. Others include, at the very least, altruism, a sense of duty and equanimity. By altruism, I mean a willingness to give through real sacrifice without expecting anything in return: To do good things for the patient, their family - as well as the larger human family – just because it is right and good to do so. A "sense of duty" in my mind means a commitment to continuity of care in the broadest sense unfettered by constraints of time or personal commitment or need.

And equanimity – the final virtue I will discuss today as part of medical professionalism – comes from two Latin words meaning an "even spirit," or good temper, which I translate to mean "one who doesn't lose his or her mind when all around them are losing theirs." This issue, professionalism, is so important! I believe its decay is the root cause of much of the trouble in health care today. So, I must be very specific about it. At the UCHC, UCSOM our graduates must demonstrate the knowledge, skills, attitudes and behaviors necessary to promote the best interests of patients, society and the medical profession. Specifically, they will demonstrate:

1. Honesty and integrity with patients/families, peers and the health care team.
2. Reliability and responsibility by completing duties in a timely fashion and not engaging in patient care responsibilities if emotionally or physically impaired.
3. The ability to maintain appropriate confidentiality.
4. Respect for others, including appropriate grooming, punctuality, courtesy, inclusiveness and use of socially acceptable language and humor.
5. Compassion and empathy in words and deeds when dealing with patients/families, peers and the health care team.
6. Awareness of appropriate professional boundaries and the inappropriateness of the exploitation of patients for any private purpose.
7. The ability to accept responsibility for errors.
8. Recognition and acceptance of personal limitations in knowledge, skill and behavior, seeking guidance and supervision when appropriate.
9. The ability to recognize the role of personal values and priorities in their practice of medicine.
10. The ability to identify and appropriately respond to unprofessional behavior in others.
11. Altruism and advocacy demonstrated by a commitment to promoting health care needs of patients and society and to improve quality and access to care and a just distribution of finite resources.
12. Recognition of and sensitivity to culture, race, disabilities, age and other differences in order to prevent health care discrimination.
13. The ability to identify potential conflicts of interest arising from the influence of marketing and advertising, as well as financial and organizational arrangements.
14. The ability to apply legal and ethical principles to patient care, clinical research and the practice of medicine.

There will be frustration and stress, for change as revolutionary as all this is always bought at a price. The new health care system will demand courage, wisdom, temperance, even-handedness, prudence and most of all faith in my belief, which I am sure at least some of you share, that all this will work out because we, as physicians and dentists, when all is said and done, indeed, do "God's work"!

So medical and dental students and residents in GME, caught up so intimately in this health care revolution, indeed our peers now and in the future, what do they want of us? I believe they want role models and mentors - Characteristics of great teachers/mentors include:

- Stimulating
- Conscientious
- Creative
- Honest
- Original
- Entertaining and engaging
- Zest for trust and scholarship

One would think that there are many such mentors in medicine. There have been, but unfortunately more and more often today the pressures and distractions of health care delivery and financing seem to be forcing many away from a meaningful mentor relationship – unless, of course, substantial dollars are invested by the hospital or medical school – dollars that no longer exist.

I ask more often than I would like - where is the commitment so well expressed in the Oath of Hippocrates, "with purity and holiness, I will pass my life and practice my art," and also "I will freely pass on to those who come after me, my knowledge and my skills." Emphasis on freely!

And the rewards! Well, they will not be economic, but is that what success really is all about?
I recently saw a terrific definition of success:

Success

He has achieved success who has lived well, laughed often and loved much; who has enjoyed the trust of pure women, the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem or a rescued soul; who has never lacked appreciation of Earth's beauty or failed to express it; who has always looked for the best in others and given them the best he had; whose life was an inspiration; whose memory a benediction.

This was in one of Ann Lander's last columns.

But to show you that my reading is a little broader than that, consider this from the Book of Proverbs:

"Those who instruct unto righteousness shall shine with God forever."

And, finally, to show you that "nothing is really new under the sun," including my core concepts of professionalism, consider this from St. Paul's second letter to the Philippians...

Brothers and sisters.....do nothing out of selfishness or out of vainglory; rather, humbly regard others as more important than yourselves, each looking out not for his own interests, but also for those of others.

Thank you

Keynote Speaker, June 4,2004

Brain Immune Connections: The Brain's Stress Response in Health and Disease."

Esther M. Sternberg M.D., National Institutes of Health (NIH), Bethesda, Maryland, USA

The lecture will outline scientific advances in understanding the communication between the brain and immune system: the scientific underpinning of the so-called "mind-body" interaction. The idea that the mind and negative or positive states of mind, such as psychological stress or well-being, can influence health and disease has been in the popular culture for thousands of years. Recent scientific advances prove that there are many ways in which the brain and the immune system communicate and modify each other's functions. Interruptions of these interactions, through genetic, pharmacological or surgical means, leads to enhanced susceptibility to inflammatory diseases such as arthritis. Over-activity of the hormonal stress response, as during chronic stress, is associated with increased susceptibility to infections, prolonged wound healing and decreased vaccine take-rate. The presence of immune molecules in the brain, and their role in nerve cell death and survival, explain nerve cell death in degenerative brain diseases like dementia of Alzheimer's and AIDS. Immune molecules within the nervous system can also play a role in nerve repair and recovery from nerve trauma. On the basis of such findings, new drug treatments are currently being developed, such as the use of anti-inflammatory drugs in Alzheimer's and multiple sclerosis, immune treatments for spinal cord injury, anti-immune molecule drugs for stroke, anti-stress hormone drugs for arthritis or nerve chemical related drugs for improving immunity in aging.

Reference: *The Balance Within. The Science Connecting Health and Emotions*. by E.M. Sternberg, M.D., W.H. Freeman, New York. Hard cover 2000; paperback Holt, Times Imprint, 2001

Keynote Speaker, June 5th 2004

Manas and the Mental Faculty

Robert Svoboda. B.A.M.S., Texas. USA

Manas is the thinking mind, the mind that measures. By overvaluing and overusing the thinking mind, the modern urban lifestyle promotes in individuals an invidious split between body and mind. People learn to rely on the thinking mind to deal with issues that would better be dealt with by the intuitive mind, which is more responsive to the needs of the body. This lecture will outline the location and function of manas in the Ayurvedic perspective on the mental faculty, and will outline ways to promote good integration between "above" and "below," between "brain" and "brawn," steering a life path between the chasms of mental or physical burnout on the one hand and indolence in mind or body on the other, refining the relationship between our individual microcosms and their enveloping macrocosm to promote balance, ease, and satisfaction.

Keynote Speaker, June 5th 2004

The Mutual Proximity of Vedic Astrology and Ayurveda

Krishan S. Charak, M.D., Department of Surgery, Indira Gandhi ESI Hospital, Delhi, India

Ayurveda is the ancient Indian system of safeguarding life, promoting health and eliminating disease The modern allopathic system of medicine is but a constituent of the grand old Ayurveda. From the ancient scriptures it appears that Vedic Astrology preceded the medical wisdom, although they are so closely interrelated that it is difficult to separate one from the other. Disease came into existence as soon as life started. Astrology provided one of the predictive and diagnostic tools. Ayurveda then acted as one of the remedial measures and a means of "propitiation."

Astrology has been extensively used by Indian physicians, the practitioners of Ayurveda, for guiding them in the treatment of patients, for selecting appropriate moments for commencing a particular mode of treatment, and also to sow or pick up herbs to prepare medicaments. It was fairly common for a good physician to be a good astrologer. It was with the advent of the so-called modern scientific temper, which looks at every thing ancient with contempt, that astrology took a back seat. Things now seem to be changing for the better