Letters to the Editor

It Is Time to Reinvent the Wheels of Medical Training

To the Editor: Traditional medical training focuses on the basic sciences, the biogenetic model of disease, and available interventions based on this model. Such training is not always sufficient to effectively impact the health outcomes of patients, especially of those who face significant socioeconomic predicaments or are high utilizers of medical care. Physicians may view such patients as those who suffer the consequences of poor personal choices, while patients may view physicians as lacking in empathy. Over the years, we have learned as a profession that health outcomes are in fact a result of complex interplay between genetics, health behaviors, and other social determinants of health, yet we have made little progress in mitigating the social determinants that drive health disparities. We suggest three broad changes for academic medicine that may improve equitable patient outcomes.

First, medical school and postgraduate curricula should put more emphasis on the principles of public health and social medicine throughout the medical education continuum, rather than merely as introductory courses. The appreciation for a "holistic" approach to health and patient care is a skill that requires time to build.

Second, the focus of medical school pedagogy should transition from memorizing facts to solving problems. While some memorizing is essential, developing the skill to translate knowledge into action should not be delayed until the trainee is out in the "real world." Academic medicine can learn valuable lessons from many successful industries that train professionals in a stepwise process of problem solving to achieve desired goals.

Third, research priorities should include tackling important social health determinants in a multidisciplinary fashion using the expertise of social scientists, basic scientists, and community organizations. Recent efforts by institutions such as the Patient-Centered Outcomes Research Institute to involve patients and community stakeholders in research processes are exemplary efforts.

We have evidence that health outcomes are a result of complex interactions between biological determinants and social determinants. Despite great medical advances, health care disparities continue to widen, and patients remain dissatisfied with the current health care system. With health care reform at our doorsteps, now is a good time to go back to the drawing board and scrutinize our conventional training, research, and practice styles and redesign them to meet the needs of our patients so that they may achieve their highest potential for a healthy life.

Disclosures: None reported.

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Tobacco-Free Hiring Policies and Academic Health Centers

To the Editor: Huddle et al[1] write that an academic health center's (AHC's) obligation to provide care is "utterly at odds with employee smoker bans, which assign the moral status of the activity to the actor and label both as unwelcome." This is a gross mischaracterization of the tobacco-free hiring policies that some AHCs have implemented. These policies make a clear distinction between the activity of smoking and individual job applicants. Under these institutions' policies, anyone is welcome to apply—it is the activity of tobacco use that is not sanctioned.

Huddle et al focus on AHCs' obligation to provide medical care, but they ignore the equally important mission of such institutions to advance *public health*. AHCs are doing a disservice to their communities and their employees if they focus only on care and ignore prevention. According to the latest Surgeon General's Report, tobacco kills 480,000 Americans each year,[2] and AHCs are in a unique position to take a leadership role in addressing this ongoing public health crisis.

Even accepting Huddle and colleagues' narrower focus on medical care, AHCs still have reason to be concerned about the effects of tobacco use. Because of the short half-life of nicotine, addicted smokers spend much of their time at work in a state of withdrawal that frequently precipitates increased anxiety, irritability, and inattentiveness.[3] They take more breaks (under our university's tobacco-free policy, they would need to leave campus to smoke) and have higher absenteeism.[4] All of these factors can impact health care delivery, continuity of care, and the safety of patients. Surely Huddle et al would not contend that in order to express their "care" to drug-addicted patients, AHCs must hire those who abuse opiates, alcohol, or other drugs that may impair performance or risk patient safety.

There is room for debate about the impact of tobacco-free hiring policies, and we welcome more research on that issue. But we reject the view that AHCs are violating any moral obligations by adopting such policies. In our view, employers—whether AHCs or not—best express their care for employees and potential employees by providing important motivation for them to kick this deadly addiction.

Disclosures: None reported.

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References

1 Huddle TS, Kertesz SG, Nash RR. Health care institutions should not exclude smokers from employment. Acad Med. 2014;89:843–847.
2 U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Washington, DC: Department of Health and Human Services; 2014.
3 Benowitz NL. Nicotine addiction. N Engl J Med. 2010;362:2295–2303.
4 Berman M, Crane R, Seiber E, Munur M. Estimating the cost of a smoking employee Tob Control. 2014;23:428–433.

In Reply to Berman and Crane: Berman and Crane contend that smoker hiring bans at academic health centers (AHCs) advance AHCs' public health mission (which, they say, is as important as their health care mission) and express care for prospective employees. They mistake both AHC missions and the "care" in health care. While AHCs often consider public health in their decision making, health care is their central activity. AHCs cannot advance public health in any way comparable to their provision of health care—not merely because public health goals pursued coercively may offend our professional identity as *carers*, but because public health is never merely about health. Public health decisions implicate the relative value of health and other important civic priorities, such as the freedom to engage in legal activities in spite of their deleterious effects. Health professionals rightly disapprove of smoking, overeating (112,000 deaths/year),[1] distracted driving (3,328 deaths/year),[2] sexual promiscuity ($17 billion in health care costs/year),[3] and overconsumption of sweetened drinks. It does not follow that we should express that disapproval of our neighbors' unhealthy activities by depriving them of employment—unless our identity as health professionals implies not only valuing health, but conditioning our willingness to work with our neighbors on their conformity to our value for health.

Berman and Crane suggest that smokers are not good employees. Of course those who cannot do the job ought not to be hired. But the suggestion that smokers, in the aggregate, perform less well than nonsmokers, even if true (which we contested in our article), would not justify a judgment that no smoker can adequately perform simply because he or she smokes.

Berman and Crane suggest that smoker hiring bans take aim at smoking rather than the smoker. From the perspective of those banning, they are likely correct. Those on the receiving end may, however, see it differently. Smoker hiring bans certainly "provid[e] important motivation" to quit, for some. But spurs to motivation take diverse forms. Not all are equally compatible with an ethic of care, which we argue is primary for AHCs and for health care providers more generally. As care requires acceptance in spite of flaws, rather than rejection on account of them, we suggest that AHCs should lead in caring as they encourage health by hiring smokers and helping them quit.

Disclosures: None reported.

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References

1 Centers for Disease Control and Prevention. Frequently asked questions about calculating obesity-related risk. http://www.cdc.gov/PDF/Frequently_Asked_Questions_About_Calculating_Obesity-Related_risk.pdf. Accessed October 30, 2014.
2 National Highway Traffic Safety Administration; U.S. Department of Transportation. Key facts and statistics. Distraction.gov: Official US Government Website for Distracted Driving. http://www.distraction.gov/content/get-the-facts/facts-and-statistics.html. Accessed October 30, 2014.
3 Centers for Disease Control and Prevention. STD trends in the United States: 2010 national data for gonorrhea, chlamydia, and syphilis. http://www.cdc.gov/std/stats10/trends.htm. Accessed October 30, 2014.

More Hippocrates, Less Hypocrisy: Eliminate Sugar-Sweetened Beverages From Residency Lunches

To the Editor: What message do residents receive when they are fed pizza and soda pop at grand rounds on obesity? Free lunches allow residents to attend educational noontime conferences, but these trainees' dietary choices become dependent on the menu served. To encourage and enable trainees to make the healthy choices we ask our patients to make, sugar-sweetened beverages should be eliminated from lunches provided to residents as they have been from many public school lunches over the past decade.

The global obesity epidemic plagues physicians as well as our patients. The Physician's Health Study demonstrated that 44% of U.S. physicians were obese or overweight in 2004.[1,2] Doctors who counsel patients to eliminate sugar-sweetened beverages but who drink these same beverages themselves act more like hypocrites than followers of the Hippocratic Oath. Physicians ought to serve as role models for their patients. In a random sample of 201 physicians in California, physicians who considered themselves to be overweight were less likely to provide primary prevention counseling on weight, smoking, and alcohol than physicians who did not perceive themselves as overweight.[3]

A number of policies and practices can discourage consumption of sugar-sweetened beverages among patients: limiting their availability and size, labeling them with health warnings, taxing them, or banning them. Several hospitals have adopted healthy food labeling systems, where products such as sugar-sweetened beverages are flagged with a "red light" versus healthier alternatives which would earn a "green light." Lucile Packard Children's Hospital at Stanford removed all sugar-sweetened beverages and low-fiber fruit juices from cafeterias and vending machines in 2012. Public schools in California have banned the sale of sugar-sweetened beverages in elementary schools since 2003[4] and in high schools since 2005.[5]

If all residency programs were to voluntarily elect to eliminate sugar-sweetened beverages, trainees would receive a powerful message that their well-being is a priority. Instead of sugar-sweetened beverages, residency training programs could provide water or other zero- or minimal-calorie alternative beverages with free lunches during educational noontime conferences. This would not eliminate choice but only provide more healthful options as the default. Residents could still purchase and consume sugary drinks if they desired. So far, however, the wide range of healthful interventions at hospital cafeterias, public schools, and other institutions targeted at patients has eluded the resident conference rooms where these policies are taught. It's time for that to change.

Disclosures: None reported. The authors wish to thank Rebecca Blankenburg and Christopher Gardner for comments on earlier drafts of this letter.

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