

Editors' Note: The following pages feature a series of invited reviews of Kenneth Ludmerer's newest book, *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine*, the third work by the noted author and historian examining American medical education. *Let Me Heal* traces the history of resident education over more than a century, ending with present day accomplishments and challenges. Authors include US and international medical educators, residents, a designated institutional official, and a patient. Collectively, they examine Ludmerer's work in the context of their experience with the medical education system, some with nostalgia, some critically, echoing the author's quote at the beginning of the final chapter: "... the residency system had never experienced a 'golden era.' Each generation coped with the medical and cultural challenges of its own age." We at the *Journal of Graduate Medical Education* consider this book an invaluable contribution to the field and encourage everyone involved with residency training to read it.

Ludmerer K. *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine*. New York, NY: Oxford University Press; 2014.

SPECIAL BOOK REVIEW

Special Book Review	
Mapping the Terrain of Graduate Medical Education: A Patient's Perspective	HELEN HASKELL, MA

Kenneth Ludmerer's *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine* is an absorbing book that transports the reader through the evolution of physician education over 2 centuries. The discourse on the topic is much needed. Writing in spare and elegant prose, Ludmerer traces the concept of American graduate medical education from its antecedents in the unpaid apprenticeships of the 18th century to the institutionalized, heavily taxpayer-supported residencies of today. For nonphysicians, the book shines a light on a mysterious world and answers questions many did not even know needed to be asked.

Several leitmotifs define Ludmerer's perspective on his topic. Chief among these are the intrinsic contradictions that he identifies as keeping the medical residency in a state of constant tension. One of these is the inherent conflict between medical education and the economic exploitation of residents, a dynamic that Ludmerer calls the "fundamental fault line" of the residency system. A second is the tension between medical education and patient safety, potentially the central issue in the eyes of the public, but one that has been surprisingly muted over the years.

These 2 themes are closely related. The recurring debate of recent decades has centered on resident duty hours, with the controversy framed as need for sleep versus the concept

of continuity of care and learning. Yet, the primacy of the duty hours issue is in some ways curious. As Ludmerer points out, it has never really been the main concern in terms of patient care. The pivotal Libby Zion case in New York and the ensuing Bell Report that laid the basis for state and, much later, national duty hour restrictions were at least as concerned with the problem of resident supervision as the work hours that made them famous. Patient activists, too, have traditionally focused on resident supervision and the fear of "ghost surgery." But fatigue has been the issue that resonated with the public, perhaps because it is both easier to understand and fundamentally less alarming. The result has been an emphasis on 1 aspect of the problem that may have worked to the detriment of more comprehensive approaches.

Intertwined with this is the conflict between adequate resident supervision and the idea of allowing residents to develop the ability to act autonomously. In the urban charity wards where the modern residency system developed, resident physicians were given almost complete autonomy. As medicine has become more complex and faster paced, the near impossibility of doing this safely has emerged. Yet, the concomitant adjustments are not always being made. At the same time, the concept of supervision as what Ludmerer calls an "underutilized" educational tool—the idea that a learner needs a teacher—has eroded, leading to a confusion of independence with education.

Implicit in his analysis is the idea of the corrosive effect of the profit motive on both learning and the concept of professionalism. Ludmerer harkens back to the mid-20th century, when legendary medical educators interacted closely with students and patients; when residents had the time to follow the clinical course of patients throughout a hospital stay; and when academics—and not just medical ones—disdained the idea of money as a yardstick of success. Yet, even in this golden age the ideals did not carry over into resident supervision: Ludmerer quotes Yale Professor Thomas Duffy as reflecting on his residency as “a form of training that plunged young physicians into waters far above their heads.” Ludmerer sees this as exacerbated in recent years by financial motivations that have led to work compression rather than work relief in response to resident duty hour restrictions. This increased workload in an already arduous occupation has far-reaching implications in its effect on both patient care and resident attitudes: reduced compassion, reduced intellectual curiosity, a task-oriented approach to work, loss of diagnostic and other decision-making skills, and a default to overtesting and overtreatment in the absence of time to reflect and research.

Ludmerer is concerned that inflexible policies on duty hours contribute to a culture in which it is considered permissible for residents to lie about hours worked, and he worries about the moral message this sends to young people who should be learning professionalism. But this is only part of a deeper problem of transparency that dates back to the demise of the charity wards: the silence surrounding the role of residents in patient care. In the early days of the residency, charity patients agreed to participate in medical education in return for free and needed care; whatever drawbacks there may have been, the bargain was explicit and the benefit to the patient clear. For modern patients, the exchange is hidden and the benefit often may not exist at all. This is the deception that so outraged Sidney Zion when he realized the circumstances behind the death of his daughter Libby in 1984: Patients are not cared for by the physicians they believe they have hired.

This financial and ethical jerry-rigging of a system that was meant to operate in a very different world results in strikingly different realities for patients and professionals. Program directors worry about loss of professionalism in young physicians, while patients, if aware of the residency

system at all, worry about inexperienced physicians and surgeons and ill-informed decisions that may cause harm. Faculty worries about the loss of continuity of care, while patients for the most part haven't a clue as to the identity of the parade of people streaming in and out of their rooms. Above all, when the inevitable errors occur, vital information is often withheld from the patient, with complicity from the institution. These are the issues that should raise concerns as a threat to professionalism: the unstated encouragement to be less than candid about one's role in the patient's care, the denial of time to do a job thoroughly and thoughtfully, the acquiescence in the abdication of responsibility toward those who have placed trust in their providers.

Ludmerer ends his book with a thoughtful and inspiring discussion of the role of graduate medical education in the 21st century mission of health care reform. He lays out a series of sensible and humane prescriptions, including suggestions for reducing workload, improving supervision, providing faculty with time to be involved with their residents' work, and creating a culture in which residents do not fear asking for help. He points out the irony of the fact that diagnostic accuracy, the basis of good medicine, is still not included in safety and quality criteria, and that the need for not just competent, but highly competent clinicians, is largely omitted from the safety and quality agenda.

To Ludmerer, the interrelationship between residency training and the delivery of medical care is at the core of health care renewal, and the key to that should lie in the molding of skills of decision making, observing, and communicating. It should be the mission of graduate medical education to produce physicians who can, in Ludmerer's words, “think, solve problems, decipher unknowns, manage complexity, and care about their patients.” As no one needs to tell the readers of this journal, medical residency is the crucible in which the attitudes, skills, standards, and aspirations of generations of physicians are formed; and as medical education goes, so goes the state of health care.

Helen Haskell, MA

Patient and Patient Advocate with a special interest in graduate medical education