



So engaged are these students in their small-group project that long past the end of class, they're still working on a poster to reduce the hospital readmission rate for heart-failure patients—for real, not just as an academic exercise. (For more about these students, see the web-extra link.)

# Part of the Process

By Jennifer Durgin

All the lectures have been delivered. All the small-group presentations have been given. Even the final exam has been administered. And yet nine medical students are lingering long past the conclusion of the last official meeting of their small group in a required fourth-year DMS course called Health, Society, and the Physician (HSP).

The students are hammering out yet another component of their project—but not for a grade, not to present to their classmates, not even to impress their teachers, who have already left the meeting for other appointments. The students are still hard at work because they have bought into the idea that they can—and *should*—help to improve patient care.

Gathered around two laptops, the students are vigorously debating the pros and cons of various changes to a poster they're designing to raise awareness about heart failure among resident physicians.

**Historically, medical students have been taught how to work within the constraints of the current health-care system. But for medical students at Dartmouth, learning the hows (and whys) of improving the processes of care is now part of the required curriculum.**

For a [WEB EXTRA](#) video, plus more about the nine students at left, see [dartmed.dartmouth.edu/su11/we03](http://dartmed.dartmouth.edu/su11/we03).

Durgin is the associate editor of DARTMOUTH MEDICINE.



Giving students experience with group processes was a key goal of the redesigned course.

**Some of the students are more vocal and animated than others, but they're all engaged. They weren't always so comfortable with each other and with group processes, however. The first few times they met, they navigated awkward silences and struggled to figure out exactly what they were supposed to be working on.**

The poster contains key facts about the disease and how best to treat it. Some of the students are more vocal and animated than others, but they're all engaged. They've developed such a level of comfort with one another that they speak quickly and directly, without hesitation.

They weren't always so comfortable with each other and with group processes, however. The first few times they met, they found themselves navigating awkward silences and struggling to figure out exactly what they were supposed to be working on.

One of the group's faculty leaders, Dr. Alan Kono, a cardiologist (and a 1981 graduate of DMS), remembers those early meetings clearly. The students were all sitting there with their laptops open, he recalls, as they waited for him to feed them information and direct them toward a goal. Having grown up in the internet age, Kono explains, today's students are used to having information and answers at their fingertips, just a click away. "The reality is that many times you just know that there is a problem," he says. "You have to figure out [the answer]. . . . That's real life."

"For the first week and a half, we really struggled with identifying what the issue was and how we [would] tackle it," recalls a student assigned to the heart-failure group. "Is that part of the process, to be frustrated, get nothing done, to struggle? Or is there a better way for the facilitators to introduce [the projects] to us?"

That's a question the students in all the small groups asked repeatedly throughout this year's HSP course. The students were told from the beginning that the course was an experiment this year, that there were going to be some bumps in the road, and that their feedback about the bumps was welcome.

**E**stablished in 1983, HSP was the first DMS course to tackle subjects such as domestic violence, HIV, managed care, and health policy. It was also the first to focus explicitly on developing good communication skills in the next generation of doctors. And it was the first to incorporate small-group learning. Now, it is the first course at DMS—and probably in the entire country—to include a mandatory clerkship in health-care delivery science.

The radical redesign of HSP began in 2010, after Dartmouth College President Dr. Jim Kim gave a lecture during last year's course. Kim explained the need for a new science focused on the delivery of health care and called for Dartmouth students and faculty to lead that new field of study. At a basic level, health-care delivery science is about finding ways to improve quality in health care, while restraining or lowering costs. (For more on health-care delivery science, see [dartmed.dartmouth.edu/f10/f02](http://dartmed.dartmouth.edu/f10/f02).)

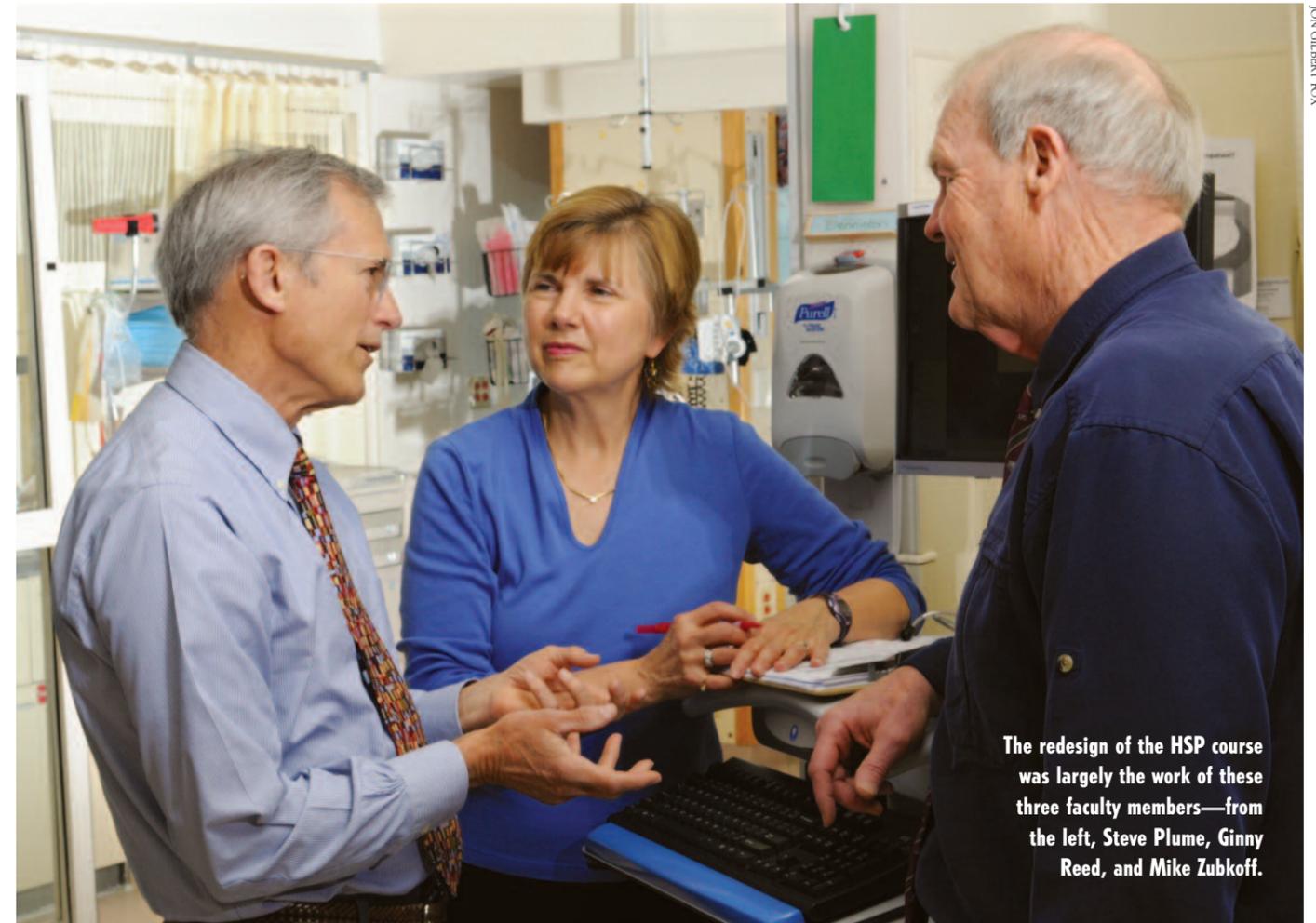
"The course this year is a direct response to his call to arms," explains Dr. Stephen Plume, a retired cardiothoracic surgeon, the former president of the Dartmouth-Hitchcock Clinic, and a member of the planning committee for HSP.

Kim "really challenged the students to think about how poorly we execute so many things in health care," says Dr. Virginia Reed, who earned her Ph.D. in experimental psychology from Dartmouth in 1997 and has been a course director for HSP since 1999. Dr. Michael Zubkoff, chair of the Department of Community and Family Medicine, also helped direct HSP this year.

Together, Reed, Zubkoff, and Plume decided to take on Kim's challenge and create what they believe is the first clinical clerkship in health-care delivery science anywhere in the country. In other words, in addition to attending lectures, all of the students were assigned to a small group to work on a real-life quality-improvement initiative. The hope is that these students will graduate from DMS with a solid understanding of clinical quality improvement and a readiness to make changes—even if just small ones—as they enter their residencies at other institutions across the country.

"We do a very good job of preparing people like you for the practice of medicine," Dartmouth Medical School's dean, Dr. Wiley "Chip" Souba, told the students when he gave one of the first lectures in this year's course. "And we do a very good job of preparing you and your colleagues for the practice of research . . . [and] the practice of education." What DMS and other medical schools need to do better, he went on, is to prepare medical students for "the practice of leadership."

He elaborated on the concept later, noting that



The redesign of the HSP course was largely the work of these three faculty members—from the left, Steve Plume, Ginny Reed, and Mike Zubkoff.

"the changing landscape of medicine and the new demands on physicians require that we change the way we educate our medical students." Simply teaching them how to practice medicine is not enough. Doctors must also be leaders, Souba maintains, and part of being a leader in health care means working to make its processes and systems better by contributing to quality improvement. "We are beginning the process of curricular reform at DMS," he adds, "to create a four-year experience that prepares our students for the practice of medicine and the practice of leadership."

**U**ntil this year, DMS students have gotten only a little exposure to quality improvement, health-care systems, and the health-policy research that Dartmouth has become internationally known for. The standard course content in quality improvement, health-care systems, and health-policy research adds up to about six hours of large-group lectures and discussions in Years 1 and 2, according to a recent paper by sev-

eral DMS faculty members for the journal *Health Affairs*. DMS students also have an opportunity, in Year 2, to boost their knowledge in these subjects through a Health Leadership Practicum elective. First offered in 2007, this elective offers second-years a chance to work in groups of two or three on a clinical improvement project. But so far, only a handful of students each year have taken the elective, which totals about 30 hours. Still, this modest exposure appears to be much greater than is offered at many medical schools in the country, even before this year's changes in HSP—not to mention further curricular changes that are underway.

A study group led by Dr. Gregory Ogrinc, an associate professor at DMS and a graduate of Dartmouth's health policy program, recently made several curriculum recommendations. The group, which included three students, suggested that Year 1 incorporate more material on the structures, processes, patterns, and people that make up health-care systems. To Year 2, the group suggested adding coursework on the "pathology" of systems—

**"The changing landscape of medicine . . . require[s] that we change the way we educate our . . . students," explains Dean Chip Souba. Simply teaching them how to practice medicine is not enough. Doctors must also be leaders, Souba maintains, by contributing to quality improvement.**



Scottie Eliassen, center, was one of the faculty facilitators for the group that Kono led.

**“As some of us leave Dartmouth and go to other institutions,” says fourth-year student Matthew Ippolito, “we’re going to come away with important concepts . . . that are really part of the Dartmouth culture but also, more and more, are part of the national conversation.”**

what makes them perform well or poorly. A goal of these curricular changes is to have students not just think about what is the right treatment for a certain disease or condition, explains Ogrinc, but also think about “how do you make the right treatment occur reliably” within a system.

**F**or example, the American College of Cardiology and the American Heart Association recommend that someone having a specific type of heart attack—an ST-segment-elevation myocardial infarction—should have the blocked artery cleared within 90 minutes of arriving in the emergency department. But sometimes that target is missed because of delays in administering the necessary tests or in rounding up a specialist to do the intervention, among other hurdles. How can a hospital design its processes to avoid such delays and meet the 90-minute goal 100% of the time?

That’s the sort of question that clinicians nationwide, including at Dartmouth-Hitchcock, are examining—and that Ogrinc and others at DMS want even students to wrestle with.

Many of the recommendations put forth by Ogrinc’s group will be introduced immediately, as of August 2011, says Dr. David Nierenberg, senior associate dean for medical education. “In fact,” explains Nierenberg, “some of those recommended changes have already been anticipated and put in place in the new [Year 1] orientation . . . introduced last August.” (For more on the overhaul of the first-year orientation, see [dartmed.dartmouth.edu/w10/103](http://dartmed.dartmouth.edu/w10/103).)

The HSP course also incorporated many of the recommendations, even before Ogrinc and his study group were finished compiling them. Since this year’s fourth-year students didn’t experience the revamped orientation when they were first-years, HSP gave them their first major exposure to quality improvement and health-care systems.

It also offered many of them their first chance—and probably their last before graduation—to hear lectures from nationally prominent Dartmouth health-policy experts like Drs. Elliot Fisher and H. Gilbert Welch, as well as other health-care thought leaders at Dartmouth. Dartmouth President Jim Kim, for example, cofounded the international nonprofit Partners in Health and is a former director of HIV/AIDS at the World Health Organization. Dr. James Weinstein, the director of the Dartmouth Institute for Health Policy and Clinical Practice and the president of the Dartmouth-Hitchcock Clinic, is the principal investigator of the nation’s largest randomized trial comparing surgical and nonsurgical treatments for back pain. And Dr. Albert Mulley, the director of the new Dartmouth Center for Health Care Delivery Science (and a 1970 graduate of Dartmouth College), was previously director of the Medical Practices Evaluation Center at Massachusetts General Hospital and a founder of the Foundation for Informed Medical Decision Making, a nonprofit dedicated to helping patients understand their health-care choices.

Having “true experts . . . talk to us about what they’re passionate about,” said fourth-year Matthew Ippolito during this year’s HSP, “is helping build a uniquely Dartmouth context in which to frame our continuing education. As some of us leave Dartmouth and go to other institutions, we’re going to come away with important concepts . . . that are really part of the Dartmouth culture but also, more and more, are part of the national conversation.”

The course also offered “a great opportunity” to hear President Kim speak, Ippolito added. Indeed, Kim’s lecture near the end of HSP came in for overwhelming praise in a DARTMOUTH MEDICINE survey to which 28 of the 68 students in the course responded.

The anonymous survey also showed that HSP helped students greatly improve their understanding of key health-policy terms. For example, 17 of the 28 students reported that before the course, they understood only “a little” or “somewhat” the term “practice variation”—that is, the existence of dramatic geographic differences, not explained by illness severity or other patient-related factors, in the amount and cost of the health care that patients receive—but that after the course they understood the concept “mostly” or “completely.” Many other



Alan Kono, right, was the clinical liaison for the small group charged with reducing the readmission rate for patients with heart failure.

students reported an improvement in their understanding of that concept to a somewhat less dramatic degree, or an understanding that began and stayed at a moderate to high level.

The survey respondents also reported almost unanimously that HSP had improved their knowledge and understanding of how the U.S. health-care system functions.

The finding from the survey that may be most encouraging to the course directors is that 23 of the 28 respondents agreed that by the end of the course, they felt “well prepared to contribute to clinical quality-improvement initiatives in the future.”

**W**hen “thinking about health policy in the past few years,” says fourth-year Richard Cheng, “it was easy to sit on the sidelines and say, ‘This problem is huge. Somebody has to do something about it. I don’t know what to do about it. It’s too ambitious.’ You kind of give yourself an excuse to sit on the sidelines because you don’t feel like there is a role for you.”

Now, Cheng says, he sees that he can play a role in improving health care, even as a student and, soon, as a resident.

Fourth-year Huawei “Katie” Dong, who was also in the heart-failure group, echoed that sentiment. “You realize that after you graduate, your role [as a resident] can impact health-care delivery [and] health-care costs,” says Dong, because residents are often the ones in a hospital writing orders.

The small-group projects in particular gave “a viewpoint into what we can do in the future,” says another fourth-year, Nicholas Tangchaivang, “to improve . . . whatever system we end up in.”

This sort of feedback is “heartening and humbling,” says Reed, who put more time and effort into redesigning the course than anyone else. The new version of HSP is not intended to be a quality improvement offering per se, or “TDI-lite,” she explains, referring to the Dartmouth Institute for Health Policy and Clinical Practice. The goal was to give DMS graduates a sense of what health-care delivery science is and why it’s important, as well as

**When thinking about health policy in the past, says fourth-year Richard Cheng, “it was easy to sit on the sidelines and say, ‘This problem is huge. . . . I don’t know what to do about it. It’s too ambitious.’ You kind of give yourself an excuse.” Now, Cheng sees that he can play a role.**



Cardiologist Jim Bell, left, was the other faculty facilitator for the heart-failure group.

**When a patient with heart failure shows up at the hospital with a preventable complication just days after a previous hospitalization, that's bad for everyone. At Dartmouth, 12% of heart-failure patients are readmitted within 30 days. That's a lot better than the national average of 23%, but Kono would like to get DHMC's rate below 10%.**

a sense that they can participate in it. And, to her delight, “they got it.”

Mulley, upon reading the students' final essays, came to the same conclusion. “I think they really get it,” he said.

But reaching that level of engagement involved a lot of discomfort and distress, most of which occurred within the small-group projects.

Each of the eight small groups was led by two facilitators and one clinical liaison—a doctor or nurse who was intimately involved with the initiative that the students were supposed to work on. The students were charged with studying the project and creating some sort of “deliverable”—a report or product—by the end of the month-long course. That was a tall order and, in the beginning, many students felt frustrated about charges that at times they felt were too vague.

“We were flailing around,” recalled one student. “We didn't have access to all the information that the leader had.”

“Most of the time when you do quality improvement,” said another student, “you're not a consultant. You're actually part of the process already. You already understand and have been exposed to it. . . . We were thrown into projects that we knew very little about and were given very little.” In addition, added the same student, “we're not trained in consulting.”

Also, the projects varied greatly; some had much narrower objectives than others. For example, one

group was charged with examining the flow of patients into and out of the Cardiovascular Critical Care Unit at DHMC and making the related processes safer and more efficient. (To view a video of their final presentation, see [dartmed.dartmouth.edu/su11/we03](http://dartmed.dartmouth.edu/su11/we03).) Another group, with a more diffuse objective, was asked to assess the progress of three DH primary-care sites that have been working to incorporate more quality-improvement processes into their practices.

But it didn't seem to matter whether the projects were technical in a medical sense or complex in a sociological sense, the students had to invest considerable time in just getting themselves up to speed on the topics.

The group led by Kono, for example, was charged with studying why some patients with congestive heart failure get readmitted to DHMC soon after being discharged—and with working on ways to reduce that readmission rate. The students had to learn about the disease and best practices for treating it; about how patients with heart failure move through the DH system in particular; and about what improvements had already been made in heart-failure care at DHMC.

Congestive heart failure, also known as just “heart failure,” is a serious, chronic, and often fatal condition in which the heart can no longer pump enough blood to the rest of the body. People with heart failure need to adhere to strict dietary guidelines, take a variety of medications, closely monitor their daily symptoms, and check in regularly with their doctor. If any of those components is missing, there's a good chance the patient will end up being hospitalized.

And when a patient with heart failure shows up at the hospital with an acute but preventable complication, just days after having been released from a previous hospitalization, that's bad for everyone—the patient and the care team. Such complications are of course dangerous medically, but also very expensive for both the patient and the hospital, which may not get paid for the readmission.

Nationally, as well as at DHMC, heart failure is one of the top reasons people age 65 and older are admitted to the hospital. At DHMC, that translates to about 275 patients a year, 12% of whom are readmitted within 30 days of their discharge. When Kono was recruited to Dartmouth in 2003 to build an advanced heart-failure treatment team, DHMC's readmission rate for heart failure was about 25%. While the improvement Kono and his team have been able to make is impressive, and while a 12% readmission rate for heart failure is a lot better than the national average of 23%, it's still too high as far as Kono is concerned. He'd like to get it below 10%.



The students had to spend a lot of time getting up to speed on the project. Here, Amy Chan, left, and DieuThi Nguyen, right, confer with Crystal Williams, a nurse on DH's cardiovascular unit.

He knows that's possible, because when he led a heart-failure care team for Kaiser Permanente in Hawaii—before coming to Dartmouth—his patients had a readmission rate of 4%.

Kono's goal of driving down DHMC's heart-failure readmission rate is one of the reasons he agreed to lead an HSP small group. Exactly how the students could help, he wasn't sure. He was hopeful, however, that given appropriate guidance and access to data and clinical staff, the students would be able to make a meaningful contribution to the overall effort to improve heart-failure care at DHMC.

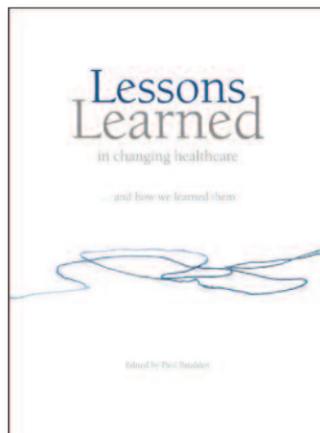
In the end, Kono was “pleasantly surprised,” he says. The group helped him realize how DH's heart-failure data could be improved and how the education of medical residents, who often take care of heart-failure inpatients, could be improved. In a survey of 29 residents, the students found that 24 of them felt they had “sufficient training” in caring for patients with heart failure—but only 19 of them

could identify all three mortality-reducing medications for heart failure. In addition to the poster mentioned earlier, the group also created a pocket card for residents with key facts and reminders. For example, the card lists those three mortality-reducing medications and includes a reminder to record patients' weight daily. (A sudden weight gain can signal fluid retention and thus a worsening of the patient's condition.) Kono plans to deploy the cards and the poster this summer.

Many of the other groups also produced materials or defined processes that will be implemented in the coming months. Reed plans to report back to the class about those implementations.

Part of the heart-failure group's success is likely because of the gusto with which Kono took on his role as clinical liaison and the dedication with which the group's faculty facilitators took on their roles. Scottie Eliassen, a graduate of Dartmouth's health-policy program and the associate director of the family medicine clerkship, and Dr. James Bell, a cardiologist at the DMS-affiliated VA Medical

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**Much to the researchers' surprise, "many of the critically reviewed evidence-based practices we had gleaned from the literature were not being followed." By carefully examining the practices in the neonatal units that had the lowest infection rates, Edwards and his colleagues were able to come up with new ideas for lowering infection rates in their own NICUs.**

## Following faculty leaders: A guide to health-care improvement

A new book that is part philosophical treatise and part how-to manual offers up the experiences of 14 physicians who have been leaders in changing the health-care systems in which they work. Like its title, *Lessons Learned in Changing Healthcare . . . And How We Learned Them* (Longwoods Publishing, 2010), the book strikes a conversational and straightforward tone. That's because each chapter is based on a talk by a different physician-leader.

Two of the contributors, as well as the book's editor, are members of the Dartmouth faculty. In fact, Dartmouth has become such a nexus of clinical quality improvement that—as described in the adjacent feature—even medical students are now involved in the effort.

"A leader's actual work offers an opportunity for learning and, if desirable, repetition," writes Dr. Paul Batalden in the introduction to *Lessons Learned*. Batalden, the book's editor, selected the 14 physician-leaders for a lecture series at DHMC in 2008 and 2009. "We invited some who saw themselves as educators, some who thought of themselves as researchers, and some who saw their work in the 'operations' of healthcare," Batalden explains. Later, the lectures were reworked into book form.

Batalden is himself a national leader in health-care improvement practice and theory (for more about him, see [dartmed.dartmouth.edu/su06/f01](http://dartmed.dartmouth.edu/su06/f01)). He pioneered the clinical microsystems approach to health-care improvement. A clinical microsystem is a front-line unit, a place where patients and care teams meet—such as an outpatient clinic or an operating room. And that's the level at which much of the improvement described in *Lessons Learned* takes place.

Dr. William Edwards, chief of neonatology at DHMC, shares several stories in the book about how direct observation can reveal best practices that sometimes run counter to standard thinking. In the early 2000s, for example, Edwards and colleagues from other hospitals visited the neonatal intensive care units (NICUs) that had the lowest infection rates in the country. Much to their surprise, "many of the critically reviewed evidence-based practices we had gleaned from the literature were not being followed," he writes. By carefully examining the practices in those units, Edwards and his colleagues were able to come up with new ideas for

lowering infection rates in their own NICUs. They then tested those ideas in a randomized controlled trial of over 1,200 extremely tiny babies at 53 participating centers. One finding was that, counter to conventional thinking at the time, topical skin treatments increased rather than decreased the risk of infection.

"But change does not always equal improvement," Edwards cautions. "I've spent a good deal of time trying to figure out which change is improvement and which isn't."

More sage advice is doled out by Dr. Carolyn Kerrigan, chief of plastic surgery at DHMC. In her chapter, Kerrigan offers concrete examples from her own improvement work.

For instance, she describes how her section improved the availability of appointments by lengthening the time between postsurgical follow-up visits. "A typical outpatient postsurgical follow-up schedule," explains Kerrigan, "looks something like this: two days, 10 days, three weeks, six weeks, three months, six months and one year." But that is "likely much more frequent" than necessary, she says. So she decided to change that pattern.

Now, she talks to her patients by phone the evening of the surgery, sees them in person 10 days later, and then not again until six months later, unless they have concerns. With this pattern, patients don't have to take time for unnecessary visits and Kerrigan has more openings so when patients do want an appointment, they can get one quickly.

Kerrigan took a similar, concrete approach when she lectured to the fourth-year Dartmouth medical students in this year's Health, Society, and the Physician course. In fact, this year's HSP course and *Lessons Learned* share several themes. Two are leadership and responsibility, which Kerrigan points to in citing a passage from a 2007 article by Batalden: "Everyone in health care must recognize that they have two jobs when they come to work each day: doing the work and improving it," he wrote in the *Journal of the American Medical Association*.

In *Lessons Learned*, Batalden aimed to provide a venue where leaders could reflect on their experiences in health-care improvement. Sharing those experiences broadly, he writes, "enables others to see the real journeys involved in becoming a leader." JENNIFER DURGIN



Joanna Lopez, right, makes a point as Katie Dong, left, and Angela Lai listen—and learn a bit more about group dynamics.

Center in White River Junction, Vt., worked with Kono to mentor the students in how to collect and analyze clinical data, how to function effectively as a group, and how to prepare for and deliver a strong presentation. Kono, Eliassen, and Bell were careful, however, not to direct the students too much and, instead, to "allow the learning process to unfold," as Kono puts it. "Sometimes angst is good and chaos breeds ingenuity."

In fact, working so intensively in a group is "a rarity" during medical school, says Dong. "We fend for ourselves on clerkships [and] take tests by ourselves." Kono realized that and so had as one of his goals to help the students learn how to function as a "task-oriented group." He coached them on how to facilitate a discussion, how to set an agenda, and how to draw out quieter members of a group.

Such skills will serve the students well, says Eliassen, and help them to be good teachers when they are residents.

By the end of the month, the heart-failure group had become "one of the most functional groups I've

been involved with," says Bell, who has facilitated 26 HSP small groups over the years.

But not all of the groups made so much progress so easily. "Some were home runs," Reed says, implying that others struggled a bit more. There were a lot of variables, she explains, such as the project topic, the personalities of the students and facilitators, and the degree of engagement of the clinical liaisons. (This summer she'll meet with the HSP planning committee to decide how to tweak things for next year.) Still, the feedback the students gave at the end of the course showed they'd learned both how hard and how rewarding group work can be, even in the groups that struggled the most.

"You may end up in a group of skeptics or individuals with negative attitudes," wrote one student in the evaluation of the course, "but this does not mean that your group still cannot produce meaningful work."

"Hearing different ideas and having the ability to entertain concepts that you don't necessarily

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## Part of the Process

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initially agree with," wrote another student, "are crucial to effective reform. . . . I learned a lot of patience in the group and ultimately am extremely impressed by what my fellow group members came up with . . . even when initially some of their ideas seemed misguided to me."

Yet another student came away with this insight: "As much as I had appreciated the importance of nurses and other health-care providers prior to the project, I had never realized or appreciated their impact on improving and changing the system."

HSP planning committee member Steve Plume was pleased to see that the students gained a sense of the "real issues people face trying to work together across different experiences, attitudes, and perspectives." Learning how to work well in a group, even a difficult group, is an important skill for today's doctors because health care is now widely considered to be a team effort.

HSP clearly changed the way this year's DMS graduates will view their role as physicians. Only one student of the 28 who responded to the DARTMOUTH MEDICINE survey disagreed with the statement that HSP had "changed how I view the role of physicians within the health-care system." In fact, 13 said they "strongly agree" with that point.

"The thing that the course left me with, which I wasn't expecting," says Chetan Huded, "was that you can't sit on the sidelines of this. You're either actively part of the solution or you're actively part of the problem. So you have to pick where you are going to fall. There is no opting out and saying someone else will fix it."

**T**hat's just the kind of ownership the HSP course directors, the dean of the medical school, and the president of Dartmouth College were hoping for.

As another student put it: "Health-care reform is *my* problem." That sense of responsibility and leadership might inspire these soon-to-be doctors to put in the extra time and effort to make improvements in the systems they find themselves within, even during residency.

Just as it drove the students in the heart-failure group to keep chugging away at their project, even after nobody was looking. ■

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