Undergraduates look at medicine through the lens of history

The history of the U.S. health-care system "has less to do with the history of medicine and more to do with the history of America," says Allen Koop, a visiting history professor at Dartmouth. For the past several years, he has taught a popular undergraduate course that focuses on the social, political, and economic influences on health care from colonial times to today.

Koop—the son of Dr. C. Everett Koop, a DMS professor and former U.S. surgeon general—hopes students will gain an understanding of "the way we've dealt with things like insurance and access to health care throughout all of American history." Both Koops are themselves products of a Dartmouth undergraduate education—in the Classes of 1937 and 1965. (See page 10 for more on the senior Koop.)

Benefits: Few people realize, for example, that employers began providing health insurance after World War II, Allen Koop says, when the government barred businesses from raising salaries. So to compete for a limited labor supply, employers began offering such benefits as pensions and health insurance. Health insurance has been tied to the U.S. workplace ever since.

Students carry what they learn far beyond the classroom. Adam Wilk, DC '06, now works for a health-care consulting firm. "No matter what policy options we come up with, I'm always reminded of Professor Koop's lessons," Wilk says. "As he lectured about efforts to effect universal health care in the U.S., he emphasized the near impossibility of easing the financial straits of one section of the health-care system—insurers, providers, patients—without squeezing another. No wonder our country has had such trouble passing any material reform!"

Many issues the course touches on are "not usually addressed until residency or beyond," adds Jeff DellaVolpe, a DC '04 who's now a medical student at Tulane. "I feel like I have had a huge leg up on the subject."

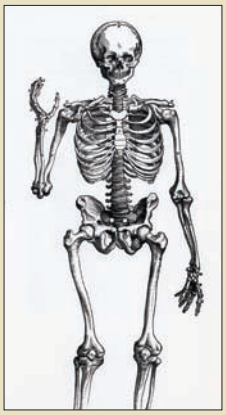
The course gives students a leg up on being a patient, too. "Everybody sooner or later ends up as a patient," Allen Koop says. He invites guest speakers to talk about their experiences with the health-care system. One guest showed the class a thick stack of paperwork generated during a battle with his insurance company. Esther Freeman, a DC '01 who's now a medical student at Harvard, never forgot him. "I always try to ask about insurance" she says, "and think about how that may be affecting a patient's ability to get good medical care."

Context: "The class was really helpful in providing context for the current health-care crises," says Justin Altschuler, DC '06, now a medical student at UC-Berkeley/UC-San Francisco. He realizes that today's problems "are really an outgrowth . . . of problems that have been present for decades . . . or centuries."

DANIELLE THOMAS

FACTS & FIGURES

Joint resolution



ANDREAS VESALIUS

1960s
When the first successful joint replacement operations were done

300,000 / 193,000
Number of knee / hip replacements now done each year in the U.S.

700 / 350
Number of knee / hip replacements now done each year at DHMC

$39,050 / $41,400
Average total charge (for hospital and professional fees) for a knee / hip replacement at DHMC

1970s
When Dartmouth began to collect failed, "explanted" artificial joints from all over the world to study the reasons for their failure

> 8,000
Number of explanted joints amassed at Dartmouth since then; it is now the world's largest such collection

1970s
When Dartmouth's Dr. Michael Mayor, an orthopaedic surgeon, and John Collier, a biomedical engineer, began to develop a porous-coated hip implant, the first cementless artificial joint

> 90%
National success rate of joint replacement operations today

SOURCES: DHMC, THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, AND THE NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES