



# PUBLIC JUSTICE *REVIEW*

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## HEALTH AND HUMAN FLOURISHING

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### Becoming a Healer

J. Todd Wahrenberger

**J. Todd Wahrenberger MD MPH** is a Board Certified Family Practice Physician and Chief Medical Officer at Pittsburgh Mercy, one of the largest community mental health centers in Western Pennsylvania. Dr. Wahrenberger has spent the last twenty-three years working in the inner city of Pittsburgh as a primary care physician and developing innovative methods of health care delivery to patients with severe mental illness.

That's not right, that's just not right, he just shouldn't live like that... I sit at a sunny table on a sidewalk in front of a café in southern California, enjoying the first day of vacation. Across the street, I watch as an elderly homeless man picks through a garbage can, producing a pizza box with a half-eaten pizza still inside. He talks to himself, makes several gestures in the air, and starts to eat the old pizza. He's pulling a shopping cart and wearing layers and layers of clothes despite the heat. Afterward, he wanders down the street and starts to yell at passing cars, he asks people for spare change, and then he wanders into an alley, most likely to relieve himself.

Down on his luck? Drunk? Mentally ill? A lifestyle choice? Is he a veteran who suffered a trauma? All of the above? He is like the patients I see in my practice day in and day out for these many years. What makes this scene even more heartbreaking is that I know there is help for him and that he doesn't have to live this way. The voices, the paranoia, the eating out of a garbage can—these do not have to be his reality. This is not the way God intended us to be. So what would it take for this person to flourish?

I work as a primary care physician in the inner city of Pittsburgh, leading a team of other primary providers, psychiatrists, therapists, care managers, medical assistants, and peer wellness coaches within a large community mental health center that provides whole person, integrated care to a population with severe and persistent mental illness. This population, on average, has a twenty-five-year mortality gap compared to the general US population, placing them as peers with those living in

developing nations. Most have co-occurring substance use, poor or nonexistent housing, and chronic, poorly controlled medical conditions along with their mental illness.

In addition to the distinction of having a high morbidity and mortality rate, this group makes up the [majority of the 20 percent of our population that uses up to 80 percent of our health care dollars](#). Our team works together to find caring, compassionate, respectful solutions across medical, behavioral, and social structures. One person at a time, we are making a difference. Getting here was a journey, a challenge, a call to a vocation in primary care, and a response to what I saw with I had to offer.

Effective primary care (Family Practice, General Internal Medicine, and General Pediatrics) has five pillars: 1) Patients need to have ongoing and trusted relationships with their primary care physician; 2) patients need easy access when necessary to receive timely treatment; 3) the primary care clinician needs to be able to manage most of the patients' medical needs; 4) when the patients need care that falls outside the primary care physician's scope, the physician must be able to effectively coordinate with specialty care; 5) the primary care clinician needs to be able to measure and monitor outcomes in the clinician's patient panel.

The current non-partisan, scientific consensus in public health is that the direction of health care for our entire population should follow a "Triple Aim": We should practice evidence-based, quality medicine; patients and providers should have a high degree of satisfaction; and health care should be financially responsible or a good value. Primary care by itself fulfills this triple aim. Primary care *integrated* with behavioral health and directed toward the highest utilizers of the health care system--even more so.

## **Why Primary Care Doctors Are Few and Far Between**

The journey to become a healer, a physician, in our country is a long, arduous, and expensive process. It shapes and forms and sets physicians on particular and specialized paths that are very difficult to later change.

Entry to US medical schools is highly selective, based largely on high academic achievement in the sciences, as well as the ability to learn and synthesize data quickly, and make and execute decisions. Being well rounded, good with people, caring and compassionate are also desirable qualities, but are harder to quantify. Only one in three applicants to US medical schools gains eventual admission. Once in medical school, students spend many long hours in the classroom, lab, and hospital wards, learning to master a very broad body of knowledge and preparing to decide in which area of medicine they will concentrate their efforts. Some students know what area or specialty they have an affinity for when they enter medical school and hope that the training process will confirm that desire. For example, some have always known that they love working with children and will be happy to be a pediatrician only to find out that while it's true that they love children, they do not like children when they are sick and would be better suited for internal medicine.

Many students are influenced to choose a specialty by their teachers, and most of those teachers are specialists themselves, working in research academics. I remember a specialist telling me “not to waste my time with primary care” and that I was “too bright to go into family medicine.” Students today tell me this is still true, but that they are getting more exposure, early in their training, to primary care.

The time required to fully train a board-certified primary care doctor beyond college is a minimum of seven years-- four in medical school and three in a residency program. Given the average cost for a US medical education, the total cost to train a brand new primary care provider, not including college, is close to *one million dollars*. If students go straight from high school to college to medical school to residency, they are getting into their first jobs around thirty and are in significant debt. This, of course, places a tremendous amount of stress on students to choose an area of concentration that will pay the bills. Primary care to a poor population just won't pay the bills or help you to catch up on student loans.

For example, a medical student looking at two very different areas of practice-- ophthalmology in a typical suburban area versus family practice in a rural or inner-city area-- will have two very different realities.

One of ophthalmology's most common procedures is cataract repair, truly a miracle of modern medicine. It's safe, easy to perform, quickly done, and it pays well. It is a relatively low-risk procedure, takes minutes, and thousands are done each day in the United States. The patient receives an almost immediate benefit, is not required to change any behavior, and is typically very appreciative of the doctor who performed the procedure.

A family practice doctor working with a Severe Mental Illness (SMI) population in the city might say that substance use disorder complicating diabetes and hypertension is one of the most common conditions diagnosed and treated. (Chronic addiction to street drugs, tobacco and alcohol make treatment of other chronic conditions like diabetes and high blood pressure very difficult as they affect those conditions in a negative way.) Unfortunately, we've had very little success in finding a cure, it typically takes years to diagnose and treat, and it requires will on the part of the patient to participate. In addition, a new medicine has not been brought to the market for treating this condition in fifteen years, and insurance typically does not pay for treatment or places significant restrictions on coverage. In other words, the doctor needs to treat a patient over a long period of time, receives a low reimbursement for the treatment, and is sometimes in an adversarial relationship with the patient.

While we certainly need physicians who are willing to do specialized medicine, the fact remains that last year, only fifteen percent of US medical students chose to enter a primary care residency, and even among those who did, most did not choose to work with the most vulnerable. Our current system of training physicians ends up selectively screening for individuals who desire a specialized area of practice, generally trains them in large, highly specialized academic training centers, and then financially incentivizes them to work in areas of practice with highly reimbursed procedures.

Given the financial pressures, the time it takes to train a physician, the intensity of training over an extended period of time, and the low priority of primary care in the educational process, I am thankful that anyone chooses a primary care specialty. But is there hope here? What can be done or is already being done to help encourage students to choose primary care, particularly for vulnerable populations, where integrated care has the potential to significantly reduce health care costs?

### **Changes Happening, Changes Needed**

I've been encouraged to see that the training process has been slowly changing in the United States over the past two decades since I was a student. More programs are encouraging primary care as a career choice by making primary care a required rotation for students and placing more primary care practitioners in the teaching curriculum early in medical schools. Physician Assistants and Nurse Practitioner programs are also growing at a fast rate. These training programs are predominantly producing primary care providers at a fraction of the time and cost while maintaining high patient satisfaction and high levels of quality in general.

The process for students entering medical school remains highly competitive and selective for students with STEM majors. Interestingly, if you have a STEM undergraduate degree, you are much more likely to become a specialist than if you have a degree in the humanities. Humanities undergraduate students are much more likely to choose primary care or psychiatry once finishing medical school. Selecting more "non-traditional" students with liberal arts degrees who also show a high aptitude for science is something to be seriously considered. Also, more scholarship programs and loan repayment programs for students choosing to work in primary care in underserved populations need to be maintained and enhanced. Historically, some church denominations and mission societies have sponsored scholarships for medical students and should be encouraged to continue to do so.

On a personal level, it was very important for me to find mentors or role models who had been out in the world, attending to the most vulnerable with care, compassion, and quality treatment. As early as high school, students should get exposure to primary care and should have opportunities throughout their training process to be matched to doctors, nurse practitioners and physician assistants that they can dialogue with during the long training process. For me, finding mentors who modeled care and compassion made a huge difference, and because of that, I make an effort to train students on rotation and to promote primary care and integration with behavioral health. I know that many others do the same.

Finally, on a governmental level, health care reform needs to continue to grow in a direction that provides all of our citizens with basic, high-quality, value-based care. The United States is still ranked at the [lowest tier among developed nations](#) for health outcomes, but we spend more than any other country in the world on health care by a very large factor. We also have the largest disparity between

rich and poor with respect to life expectancy of any developed country on the planet. If other developed nations have figured this out already, why can't we?

Other nations have decided that health care is a part of a just public infrastructure, like a police force, school systems, and road systems. They have found that insuring all citizens with basic health care based upon primary physical and mental health care that is highly integrated provides the best opportunity for all of the citizens to thrive. The Affordable Care Act was a good start in that direction, but it is not nearly enough. It needs to be constantly improved, rather than tossed aside and replaced with a system that may worsen health care disparity without adding value.

### **Caring for the Whole Person**

As Maslow's hammer refrain says, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail." Our current health care system, from the top to the bottom, assumes that health care is a privilege and a commodity and that sickness is the result of personal choice and weakness. We have educated those most likely to treat the body like it was created in the image of a machine, and we pay them for fixing parts, not the whole person. Our medical practitioners enter the workforce in the middle of their lives with a mountain of debt in a system where they are paid the most to do something for a consumer rather than walking alongside a patient. And so we produce many hammers.

Whether I look at all this from a public health and economic perspective or my own personal belief as a Christian, I keep going back to the man eating out of a garbage can. He has a broken body and a broken brain and, just like me, a fractured soul. And because he is like me, because he is my brother on the road, I need to understand what it would take to really help him. He is not, essentially, a machine that needs a body part replaced, although he may need that too. He is a person created in the image of God.

What would it take to really help? It would take someone to walk alongside him, to talk to him, to get to know him, to have care for him. It would take a system with trained health care professionals who can help him when he is ready to get into safe housing, and quality medical and mental health care, as well as substance abuse treatment. Not only would this save our health system money in the long term but, more importantly, treat a fellow human the way that God has intended us to "do unto one another."

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