Medical Schools at the Crossroads

by Richard J. Margolis

The nation's 114 medical schools are represented in Washington by what people in the health industry call "the double AMC," which is short for the Association of American Medical Colleges. That estimable organization found its way to Dupont Circle in 1969, after dozing for nearly a century in drowsy Evanston, far from the action and as far from the mint. The move symbolized the medical schools' new status in America: they had become a national issue and were fast becoming a national ward.

In the opinion of some—Dr. Howard Levy, for example, a staff analyst for the reform-minded Health Policy Advisory Center—the AAMC is "the single most powerful health lobby in Washington." The estimate seems a bit strong considering that the group must compete for the championship with more experienced big-letter lobbies like the American Medical Association (AMA) and the Health Insurance Association of America (HIAA); but it is true that AAMC people spend a lot of fruitful time in congressional corridors and hearing rooms. It is also true that many of our medical schools of late have become addicted to that most potent of institutional drugs, the federal appropriation, and that they generally rely on the AAMC's capitol efforts to support their habit. At first the new federal subsidies seemed to contain a promise of fundamental health reforms: later there arose a suspicion that most medical schools preferred to take the cash and let the promise go.

Last year almost half the medical schools' total revenue came from federal grants and contracts, while tuition fees accounted for a paltry 4 percent. Over the past decade federal spending for health manpower programs has increased from $65 million a year to $536 million a year. The 10-year total comes to $3.5 billion, and that leaves out much larger sums paid by the government to medical schools in the form of research grants and reimbursements for services—like Medicare payments. "The federal government," notes Rosemary Stevens, an associate professor of public health at Yale, "has become the medical schools' new proprietor."

Much of this appears to be a legacy of the nation's

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oft-disputed doctor shortage, a shortage long denied by the AMA but long trumpeted by the AAMC. In 1959 Ward Darley, then president of the AAMC, warned of an impending manpower crisis, "the most serious that medical education [will have] faced since the Flexner Report." In 1963, despite AMA opposition, Congress passed the Health Professions Educational Assistance Act, the first visible sign that Washington was prepared to subsidize medical education in addition to medical research. The result has been 20 new medical schools and thousands of new physicians, and the ratio of doctors per 100,000 patients has risen from 137 in 1962 to 158 in 1973.

It is an index of the reigning confusion in medical academia that no one can say for certain whether we have finally overcome the doctor shortage or merely dented it. The subject inspires endless debate and study. As recently as 1970 Dr. Roger Egeberg, former assistant secretary for health in HEW, declared that "the United States now needs 50,000 more physicians, a couple of hundred thousand more nurses, and almost 150,000 more technicians." But some experts, including those who now speak for the AAMC, are saying that Egeberg's estimates no longer hold. In any case, doctors and politicians have dumped the old conundrum in the lap of yet another study committee, this one called the Commission of Physicians for the Future, funded by the Josiah Macy Foundation and chaired by Dale R. Corson, president of Cornell. "Our mission," says Corson, "is to look at the resources of medical schools as they affect the health of the nation."

Ever since King's College (later Columbia) organized the country's first medical school in 1767, the quality of health care in America has been closely linked to the quality of medical education. Through much of the nineteenth century the medical profession struggled to establish a system of schooling and licensing that would ensure high standards of medical practice and also eliminate the cutthroat competition then rampant among physicians. The cause of improved medicine thus became synonymous with the cause of monopoly medicine—that is, of stricter licensing regulations and fewer doctors.

In those days one became a doctor either by being apprenticed to an experienced practitioner or by briefly attending a medical school, most of which were private and profitable fly-by-nights where anyone with the price of admission was welcome. The typical medical student in the mid-nineteenth century had completed just five grades of elementary school and was semi-literate. When the president of Howard in 1869 tried to institute written examinations for medical degrees, he was told by the medical school director that only a few of his students could write. To be sure, there were a few bright lights amid the general gloom: Harvard (founded in 1783), Yale (1812), Western Reserve (1843), and Johns Hopkins (1893) all pursued excellence and ran ahead of the pack, but even those worthies lagged behind their European counterparts. Harvard did not include the stethoscope in its curriculum until 30 years after its invention.

It was not in the interests of most medical schools to clean house. So long as standards were lax and licensing laws liberal—or nonexistent—the schools were free to ply their trade and make their profits. But educational reform was in the interests of both doctors and patients—patients, because it might reduce quackery and raise the quality of care; doctors, because it might cut competition.

Accordingly, the American Medical Association kept calling for stricter standards and fewer physicians. The AMA had been organized in 1847, but it was merely one of several competing societies and did not accumulate any real power until the turn of the century. Significantly, the AMA's climb was slowed by the medical schools, whose representatives during the organization's early years were able to out-vote the other members and thus to veto all proposals for educational change. In 1874, however, the AMA leadership eased school members out of the club, compelling them to start a separate and unequal organization, the AAMC.

By 1904 the AMA had won a reputation within the profession and was ready to go forth to slay collegiate dragons; the *AMA Journal* threw the first spear. As the association's official historian, James Burrow, describes it: "...the editor...called attention to the backward state of medical education, and to the flood of graduates that annually took their place in the profession. He noted that medical schools, numbering 90 in 1880, had increased to 154, which would supply the nation with twice as many physicians as would be required to maintain the already 'absurdly crowded conditions.' "

Note that the AMA's main concern was not education but business; the writer struck the gong of economic self-interest, and it is still echoing. But the association had a strong case—medical education *was* in disarray—and before long it found an ally in the Carnegie Foundation for the Advancement of Teaching, which underwrote a study of medical schools to be coauthored by one of its staff members, Abraham Flexner, and Dr. Nathan Colwell of the AMA's Council on Education. The two men visited every medical school in the country. Their findings, published in 1910 as the Flexner Report, startled the medical world and set the course of medical education for at least half a century.

The Flexner Report, notes Rosemary Stevens in her superb book, *American Medicine and the Public*

Interest, "provided for the first time a detailed exposure of the medical schools by name, and in so doing it brought to public notice the appalling conditions of many of the schools." Kentucky was labelled "one of the largest producers of low-grade doctors in the entire Union"; Chicago, "the plague spot of the country." Few schools got a clean bill. Even Yale, hardly one of the worst, fell short of the mark by virtue of its overworked instructors and its lack of postmortems.

Because of the Flexner Report, 92 schools either merged or went out of business, and most of the remaining 85 soon raised their minimum entrance requirements to at least two years of undergraduate schooling. Henceforth medical education was to follow Flexner guidelines, which meant, among other things, strict admissions policies, four-year curricula, and a heavy emphasis on medical research. It also meant that medical schools would cease to be profit-making businesses. The high standards Flexner recommended—the large teaching staffs, the elaborate research programs—required funds on a scale not to be matched by tuition fees.

Flexner foresaw the problem and may even have foreseen the "solution." For while calling for private endowments, he hinted that government funds would also be needed. "Practically," he observed, "the medical school is a public service corporation," leaving open the question of whether a public service corporation ought to be supported by public revenues. As every medical dean knows, that question has now been answered.

A handsome oil portrait of Abraham Flexner hangs from a wall in the AAMC reception room; and if the gentleman looks somewhat bewildered, it isn't any wonder. His reforms have been fully realized—year by year and step by step—but now the medical schools have begun, in some measure, to reverse themselves because of the general fear of a shortage of doctors. For example, 46 medical schools now permit at least some students to complete their course work in three years instead of the customary four. Similarly, many of the bedrock courses which Flexner said no medical student could do without have been demoted of late from basic requirements to mere electives. At Stanford's medical college *all* courses are electives.

Flexner's legacy, it turns out, gave us better but fewer doctors and fewer but better medical schools. In the end it saddled these schools with intolerable financial burdens which could only be carried with massive federal aid, and much of that aid has weakened the colleges' hold on self-determination and mocked the myth that health care is part of our free-enterprise system.

To discover what system health care is part of, one must look to Washington, and this is an instructive moment. Authorization for funds from the Health Manpower Training Act (HMTA), legislative successor to the 1963 act, will end on June 30, and no one knows whether Congress will simply renew the measure for another three years or decide to rewrite it, perhaps drastically. Hearings are being held and contradictory recommendations are being made; it is a tense time.

The tension can be attributed to new pressures for health reform and to a rising suspicion among reformers that medical colleges, though they ballyhoo solutions, are really part of the problem. Reformers would like to graft their vision of a sensible health care system onto medical school appropriations, trying in effect to rechannel the profession by recultivating its spawning grounds. For example, Kansas Congressman William Roy, himself a physician, has submitted a bill proposing direct federal loans to medical students which they would later "pay back" by serving for two years in a rural community or in an urban ghetto, places not commonly frequented by doctors.

Other measures being considered include one submitted by Congressman Paul G. Rogers (D., Fla.) who chairs the House Subcommittee on Public Health and Environment, and another offered by Senator Edward M. Kennedy (D., Mass.), chairman of a similar subcommittee on the Senate side. Both would extend, with few modifications, the expiring Health Manpower Training Act with a final price tag yet to be settled. In addition, as of this writing, there is rumored to be an administration bill in the offing, one considerably less lavish than either the Kennedy or Rogers proposal. A clue to what the Nixon bill might contain—or, in terms of dollars, might not contain—can be found in a speech delivered last November by the assistant secretary for health, Dr. Charles C. Edwards. "In my judgment," said Edwards, "...we may well be facing a doctor surplus in this country. A number of authorities now see this as a distinct possibility, one that must figure very heavily in both our immediate and long-range planning in the health manpower field." In other words, it's time to cut back.

Altogether there are 14 bills in the congressional hopper having to do with medical schools, plus a brace of amendments, some of which are calculated to drive medical deans to despair. New York Senator James Buckley's "right to life" amendment, for example, would make it illegal for researchers to undertake fetal experimentation. "It's an anti-abortion amendment," says an AAMC spokesman, "and it would wipe out pediatric research."

Such proposals strike most persons in the medical college establishment as a cruel continuation of the cat-and-mouse game they claim Congress has been

playing with them since 1963. "They give money and they take money away," complains Dr. John A.D. Cooper, the AAMC's energetic president. "They have to recognize that a medical institution is a system, and when they keep switching signals the system becomes unstable—it oscillates." Cooper dismisses the Roy bill as a "silly idea," and calls instead for federal "capitation" funds whereby the schools receive a fixed sum for each enrolled student. That sum, under the old HMTA formula, has been about $1,700.

What the schools ask from the federal government, then, is what grantee institutions invariably ask and seldom get: a steady, generous flow of administrative support funds unencumbered by strings. Moreover, they want the cash sent directly to the dean's office and not, as the Roy bill envisions, handed over to students. If they have their way, they will bypass liberal hopes that America's system of medical education can somehow become the cradle of health reform, the place where radical institutional change may begin.

Medical colleges are, however, beginning to feel the lash of public discontent with present health care arrangements, since a portion of that discontent has seeped into the legislative language. The maldistribution of medical services is only one of the afflictions for which health reformers tend to blame medical colleges. They also give the schools bad marks for the nation's scandalous surplus of surgeons and the accompanying shortage of "primary care physicians"—pediatricians, internists, and general practitioners. Four decades ago eight out of every nine doctors in America were in primary care; today the ratio is one in four. Everyone in the health care industry knows that primary care doctors provide a kind of service not commonly offered by specialists: they treat the "whole patient" instead of the organ, they spend more time with the patient, they are more frequently available, and their fees are lower. There is even evidence to suggest that patients of general practitioners spend fewer days in hospitals than do patients of specialists.

Accordingly, the Congress in recent years—through a system of special grants and contracts—has encouraged medical schools to teach "family medicine," the latest euphemism for general practice, and most of the schools have willingly added such courses to their curricula. But somehow the idea has failed to pay off. For one thing, it has been difficult to recruit faculty. Last year, of the schools' 413 budgeted positions for teachers of family medicine, only 342 (83 percent) were filled. Teachers for other clinical fields were much easier to find; in psychiatry, the 3,300 faculty members occupied 97 percent of available positions.

Then too, the big teaching hospitals, many of them part and parcel of the medical colleges, have been slow to respond to the push for more primary care doctors. The residencies they offer to medical school graduates still focus on the specialties at the expense

of family medicine. Two fifths of all first-year residencies and fellowships are in surgery, a clear and melancholy signal that the profession, by and large, continues to trudge down a discredited road.

Reformers also note that many medical colleges have turned into enormous medical centers—establishments attracting thousands of researchers and millions of patients—and that their hugeness contributes to such national woes as soaring hospital bills, a high incidence of needless surgery, and impersonal or assembly-line medicine. Most medical school officials will concede the point, but neither they nor their critics have found a solution. "We wish the realities were not so intractable," a health administrator at a Midwestern university wrote to me recently, "but we will lurch along somehow."

Most of the intractable realities have dollar signs: the high cost of medical research, the soaring salaries of interns and residents, and the runaway inflation of medical prices, this last in part the consequence of overly generous federal reimbursement policies. (Under Medicare, for example, the government giveth and the hospital taketh away.) The result is that taxpayers and patients are subsidizing medical colleges in ways not generally understood or accounted for.

Finally, medical schools are being attacked for accepting too few applicants and too many of a single type. Three quarters of the 26,000 rejected applicants last year, according to the AAMC's own figures,

"were fully qualified," an astonishing statistic in view of the putative doctor shortage. Many of the frustrated aspirants will get their medical education abroad, later to return in pursuit of careers. Indeed, half the doctors licensed last year to practice medicine in the United States were graduates of foreign medical colleges, and the AAMC's response to this trend tells us much about medical school attitudes: rather than lobby for more colleges and larger enrollments, the association is on the verge of taking what a spokesman calls "a very tough stand toward foreign-educated doctors." If the AAMC has its way, the returned exile will be required for licensing to take courses in U.S. medical schools—precisely what he was not allowed to do in the first place.

Meanwhile, the successful applicants remain predominantly white, male, and affluent, though it is true that some schools have gone out of their way in recent years to redress the balance. Blacks now comprise 6 percent of the total enrollment compared with 3 percent in 1970. (The figures exclude Meharry and Howard, which are all but exclusively black.) And women's enrollment during the same period has risen from 9 percent to 13 percent. But these gains, admirable as they are, hardly dilute the fundamental elitism that undergirds medical admissions policy. One out of every three medical students in the U.S. today is the son or daughter of a doctor, an understandable but discouraging figure on the social mobility index.

Reformers worry both about the elitism of this system and about its impact upon the quality and distribution of health care. They point out that because so many medical students grew up in the suburbs, they are unlikely as physicians to choose a rural practice. (Besides, nearly all medical schools and centers are urban-based; the five states still without a medical school—Alaska, Idaho, Maine, Montana, and Wyoming—are predominantly rural.)

Beyond this, there is the widespread feeling that medical school admission standards somehow screen out the idealistic and the dedicated in favor of the pedestrian. Tom Moore, Jr., until recently head of the Teamsters' health planning program in California, has circulated among colleagues an acidulous memorandum on the backgrounds of medical students and young doctors:

"The overwhelming majority of medical and dental school graduates comes from upper-income...families with a business background. The health schools of this country are glutted with the bright children of real estate salesmen and bank clerks...[who] are remarkably competent at the disciplines associated with minimal scientific analysis. In fact...the second choice of occupation for most medical and dental school applicants is engineering. How do you like that? Our health schools are populated by a horde of toaster- and missile-makers who had the grades or the connections or the sheer tenacity to get into medical school. Otherwise, they would have settled for designing systems for loading solid fuel into ground-to-air missiles...."

Moore's message, itself marked by a kind of reverse elitism, is that doctors steeped in the business ethic are not likely to indulge dreams of humanitarianism; they would rather be surgeons in Scarsdale than family practitioners in Whitewater, Kentucky. The schools reply that the exigencies of the profession require that they recruit the best and the brightest, not necessarily the saintliest. Test scores of medical students, claims the AAMC, are second highest of any student group in the nation—behind nuclear physicists. "We don't investigate their consciences," growls an association official. "We measure their aptitudes."

Reformers insist, however, that the conduct of medical colleges, unlike the conduct of other academic baronies, is a matter for national debate and decision. As the medical schools go, so goes the health of the nation—and if that idea seems rather too simplistic to explain the complex challenges of our health care system, it at least has a useful and honorable history, beginning with the preachments of Flexner and the early AMA.

On balance, and despite all the recent federal *caveats* and incursions, it must be said that our medical colleges remain surprisingly indifferent to the urgencies of reform, preferring for the most part to leave that difficult matter to the politicians. There is little evidence that medical schools see themselves as "a public service corporation." Few colleges have responded with any enthusiasm or long-range determination to the nation's health care needs; few have stressed to their students the virtues of rural practice or the sins of excessive surgery; and hardly any have invested sufficient dollars and prestige in promoting the education of family practitioners.

All institutions, including those with the best of intentions, would rather be solvent than right—which is why the dollar shortage alarms medical deans far more than the doctor shortage does. And yet, as the late Dr. Alan Gregg warned an audience of medical professors 20 years ago, "Who can deny that stability can be pushed too far? We must needs adjust the institution to change—or see it perish of its own brittleness." No one has prophesied the crumbling of medical education, but it seems probable that we have seen the last of medical schools as we once knew them—that is, as engines of a laissez-faire health delivery system, unfettered by public funds and untroubled by public considerations. The carefree days have vanished. Their loss, one hopes, will be the patient's gain. ■