Why 117 Medical Schools Can't Be Right

by Richard J. Margolis

But nothing is more estimable than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it... and exercises the art with caution, paying equal attention to the rich and the poor.
—Voltaire

As for doing good, that is one of the professions that are full.
—Thoreau

The modern medical school—half temple, half academy—worships modern gods: Enlightenment, Technology, Mammon. Yet it is a direct descendant of the Greek *asclepieia*, ancient medical centers where a sick person could repair for treatment or an ambitious youth could enroll for training by the physician-priests. Like all professionals, the faculties of those early medical centers tended to mistake doctrine for truth: They followed the putative teachings of Aesculapius, son of Apollo. Homer called him "the blameless physician." He is said to have been so skilled in saving lives that Pluto, the proprietor of Hades, at length accused him of causing a serious shortage of shades, whereupon Zeus smote Aesculapius with a thunderbolt and thereby conferred upon him a new vocation, that of a martyred deity. Physicians and medical educators have been invoking his spirit and monopolizing his knowledge ever since.

Nowadays the heirs of Aesculapius may be the target of a second, though less definitive, thunderbolt, this one brandished not by Zeus but by the public, a new, democratic god with a relatively weak arm. The thunder has special meaning. In most societies a bargain is struck between priesthood and public: The priesthood dispenses esoteric but necessary services to the public, while the public grants special rewards and privileges to the priesthood. All goes well until the agreement jumps the track, as it has done of late in American medicine, where the services often seem threadbare and the privileges excessive. When that occurs, institutions have been known to topple and new ones to take their place. Social scientists call such an event revolution; theologians call it reformation; the American Medical Association calls it socialized medicine.

This essay will focus on some of the public's discontents, drawing connections between these and current medical school practices. In particular, we shall examine what amounts to a national policy on admissions—the rules of the game that ordain who and how many are allowed to enter the medical profession. More than any other single factor this policy influences the demography, and therefore the availability, of health care in America.

It was probably inevitable that the crisis of confidence in our health care system, a disenchantment revealed in opinion polls as well as in a skein of gloomy testimony at congressional hearings, would eventually overtake the 117 accredited medical colleges that are the system's prime incubator. Most of the questions about health care now being raised by politicians and commentators—e.g., Are there enough doctors? Can they be equitably distributed? Is the fee-for-service system obsolete? Can galloping inflation be reined in?—compel a hard look at the academic source, where doctors are explicitly

RICHARD J. MARGOLIS, Change Magazine's literary editor, is writing a book on reform of the health care system.

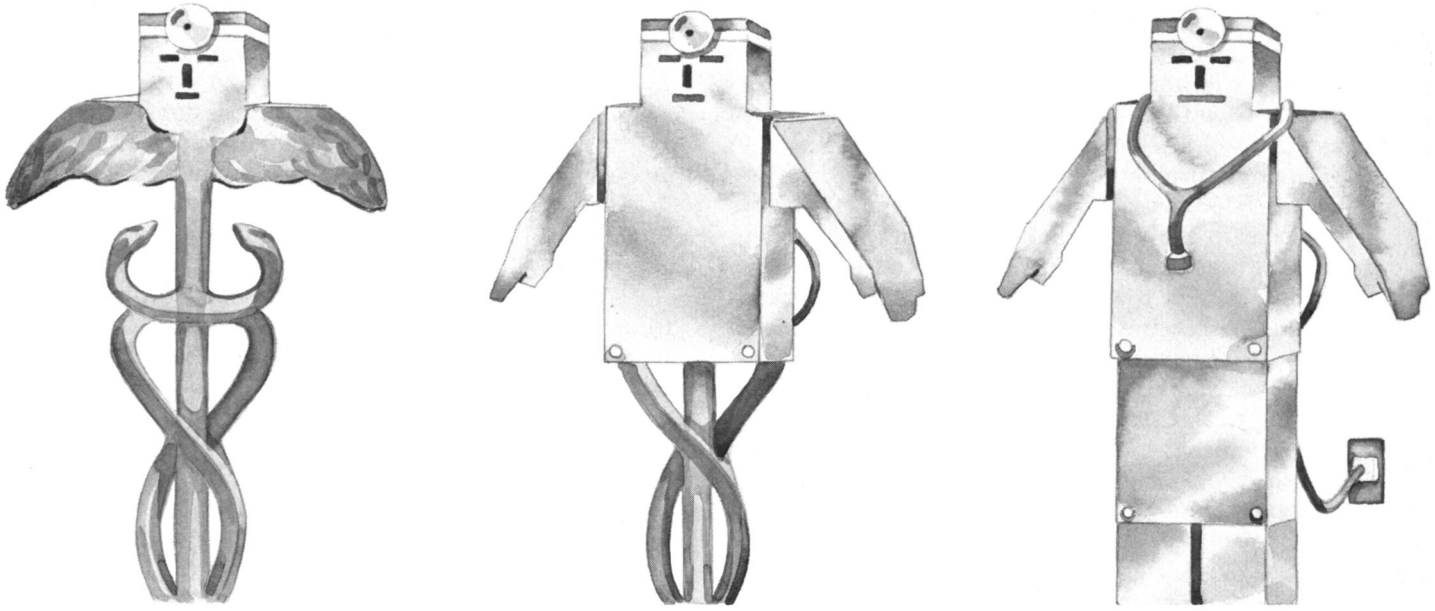

Illustration by Robin McGrath

made and health care policies are implicitly shaped. These powerful institutions play a seminal role in defining our medical arrangements: through the types of students they admit (and reject), the kinds of internships and residencies they make available, and the social climate they promote. They are the health care network's chief source of professional energy; what they preach is what we get.

What we have been getting in recent years has suited neither our needs nor our pocketbooks. The medical clan today is guilty of a variety of excesses: Its services are generally overpriced and its practitioners are both overspecialized and overconcentrated in affluent neighborhoods. One result has been rampant inflation, with health care prices during the seventies rising at nearly four times the rate of the overall Consumer Price Index. The cost spiral has imposed a dollar blight on all new programs. Medicare premiums paid by the elderly, for example, have been increased on eight different occasions since the program's inception in 1965.

Inflation has been made worse by a proliferation of specialists, who as a rule rely on more expensive diagnostic techniques and charge higher fees than do general practitioners. In 1931 only 17 percent of the nation's doctors were specialists; today the figure is 72 percent. A surplus of surgeons has caused much damage, creating an irrational demand for surgical services. (Medical economics reverses the conventional rule of supply and demand by placing buying decisions in the hands of the doctor instead of the patient.) At least two million of the operations performed each year are said to be unnecessary, and lead to some 15,000 preventable deaths.

The geography of health care seems equally intolerable. Because most doctors locate their practices within easy reach of the affluent, the residents of urban ghettos and rural villages are frequently shortchanged. The state of Mississippi—relatively black, poor, and rural—has only 82 doctors for every 100,000 citizens, while suburban Westchester County north of New York City enjoys a doctor-patient ratio of 260 per 100,000. At last count some 5,000 towns in 138 counties had no doctor at all. These shortages of health care services—or maldistributions, in the parlance of medical analysts—are more than statistical failings; they signify much human heartache. To cite one instance, if the U.S. infant death rate last year had been proportional to Sweden's, 50,000 fewer babies would have died in this country.

But the public's disillusionment with health care transcends such arguments; it is less technical than it is instinctual, and at its core lies an ancient mystery: the doctor-patient relationship. The idea persists that our health care system has grown rich, remote, and shamelessly mechanistic at the patients' expense. Those of us with the means to enter the medical marketplace are likely to find it strangely indifferent to our welfare. The family doctor with his personal touch is out of fashion; the specialist with his costly machinery and tunnel vision is in. We are thumped, probed, scanned, photographed, pierced, drugged, cut, and billed—but rarely addressed and seldom heard.

Having been reduced by modern medicine to the status of a machine with broken parts, the patient often returns the compliment: He approaches the

medical system as he would a mechanical contrivance—a frightening dynamo with the power to dispense or withhold a mysterious blessing called health care. The sacred doctor-patient relationship so lovingly promoted by the American Medical Association is now just a pleasant memory; it has vanished in the wake of specialization, technology, and third-party reimbursement, which encourages doctors to view their patients as walking insurance policies. An accurate portrait of the new doctor-patient relationship would in no way resemble Norman Rockwell's painting of a kindly physician ministering to the patient at his bedside; more likely it would depict two recorded messages locked in deaf soliloquy.

A shorthand for all this is to say that doctors no longer seem to *care*, and it is this perception that causes many observers to worry about the direction medical education is now taking. The anthropologist Ashley Montague, who has spent years teaching in medical schools, makes the point well. "The teaching and practice of medicine," he notes, "have become dehumanized, and they need to be humanized. This can be done first by revising our concept of what a doctor ought to be. He ought to be one who cares, for caring is the first principle of human communication and the first step toward recovery of the patient. To secure such doctors we need to revise our requirements for entrance into medical school to include the ability to care for others."

Two major questions, then, inform the current debate over America's health care arrangements: Who shall become doctors? and What shall doctors become? At bottom, the questions strike at the very legitimacy of contemporary medical education, raising doubts about that institution's time-honored role as the profession's watchman at the gate and keeper of the flame.

"Within limits," observed the late English sociologist Richard M. Titmuss, "each distinctive culture gets the medical priesthood it wants," and it may be true that Americans have gotten exactly what they bargained for: a steeply pyramidal health care system with some 320,000 practicing physicians perched elitely at the top and about 4.5 million other health workers toiling humbly beneath. The pyramid is distinguished less by class than by caste: It has no elevators. Nurses remain nurses forever; hospital orderlies often spend their entire careers emptying bedpans. The only way to get to the top is to begin there.

One upshot of the caste-iron pyramid has been to magnify the power of the medical priesthood. They alone set the fees, make the diagnoses, prescribe the treatment. Because doctors are king of the hill, their profession suffers no shortage of aspirants. Many are called but few are chosen. Each year about two thirds of the 45,000 men and women who queue up at the medical colleges' admissions offices are turned away. For the would-be acolyte, acceptance amounts to a ticket to temporal paradise, virtually guaranteeing the initiate a lifetime of prestige and relative wealth. Doctors in America make more money than do members of any other profession. Their average reported income, according to Internal Revenue Service records, exceeds $50,000 a year, and some analysts think a more accurate figure would approach $75,000. A young doctor today can expect to earn upwards of $30,000 his first year of practice. After that, things get better; if he is a specialist rather than a general practitioner, he can aim at a six-figure annual income.

The 15,000 applicants accepted each year are considered the best and the brightest of the batch—the ones with the highest undergraduate grades and the top MCAT scores (Medical College Aptitude Test)—but it is widely acknowledged that many of the rejectees are equally bright and would probably make as competent physicians. The Association of American Medical Colleges (AAMC) concedes that at least three quarters of those rejected are fully qualified, which is another way of saying that the profession's gate-keeping policies are both niggardly and arbitrary. The complacency with which the AAMC makes this astonishing assertion underlines the bankrupt status of current admissions practices and the reluctance of the medical establishment to undertake reforms. If the Congress and the public ever hurl their thunderbolt—in the form, say, of a medical manpower *dictat*—it will be aimed at these policies, which breed elitism and create artificial health care shortages.

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Elitism corrupts, and arbitrary elitism corrupts arbitrarily—which may be why many medical colleges of late have been shaken by conflicts and scandals. "Things fall apart, the center cannot

hold...." In Pennsylvania the Speaker of the House and two other legislators have been indicted for allegedly extorting money from parents anxious to get their children into a state medical school.

Similarly, the Chicago Medical School in 1973 collected an average of $50,000 each in contributions from relatives and friends of 77 of its 91 entering freshmen. School officials have admitted under oath that the money influenced admissions chances. Such revelations are probably just the tip of the iceberg. Like the Church's selling of indulgences to medieval sinners, medical school dispensations suggest the sort of institutional rot that generates first cynicism and then reformation. The process already seems well under way. Even the Federal Trade Commission, an agency not noted for its radicalism, has begun to question the medical profession's right to accredit schools and regulate admissions. "We're being harassed by the FTC," an AMA spokesman in Chicago complained to me recently. "Four of their lawyers just about lived with us for three months running; when they left, they carted away 150,000 pieces of paper. Mind you, I'm not questioning their right to investigate a possible antitrust situation; but sometimes I wish everybody would go away and let us do our job."

Nobody is going away; everyone, in fact, seems to be zeroing in. Perhaps the most telling sign of the growing discontent is "Bakke-lash," the tendency of rejected white medical school applicants to challenge the colleges' affirmative action policies. Allan Bakke is a 36-year-old engineer who was twice rejected by the University of California Medical School at Davis—not, he claims, because he lacked the necessary qualifications, but because 16 of the 100 available places were reserved for minority-group members, many of whom were admitted on the strength of grades lower than Bakke's. Bakke took his case to the California State Supreme Court—and won. The school's appeal will be heard by the U.S. Supreme Court. (For more on Bakke, see articles beginning on page 18.)

Bakke's fight, of course, is part of the continuing American dilemma. He is a victim of racial boomerang, of the medical schools' efforts to atone for past sins. For nearly a century following the Civil War blacks and other minorities were systematically excluded from "white" medical schools; the few who became doctors were trained at Meharry and Howard, the two medical schools reserved exclusively for blacks. Even today, after almost two decades of reasonably honest minority recruitment, blacks comprise less than 7 percent of the total medical college enrollment, while the combined strength of other minorities—Chicanos, Puerto Ricans, Native Americans—accounts for less than 2 percent; and that iota has been shrinking lately. (Women continue to make gains, though they are still a long way from parity. They now represent 22 percent of all medical students, compared with 10 percent a decade ago. Female applicants I have talked to report that admissions staff interviewers are still asking women how they plan to reconcile their careers with their "domestic responsibilities.")

It is hard to see how the medical schools can redress old grievances without maintaining a double admissions standard—one for whites and another for minorities. Nor, in light of the desperate doctor shortage that prevails in most minority communities—rural as well as urban—does it seem useful to reimpose a single standard and call it equal opportunity. Studies suggest that new doctors tend to locate their practices in places similar to those in which they have grown up. It seems likely, therefore, that so long as medical schools concentrate on white, upper-middle-class applicants, we shall suffer from a surfeit of doctors in white, upper-middle-class neighborhoods, and from a deficiency of doctors nearly every place else.

If the Bakke dilemma is posed in narrowly racial terms—as a choice strictly between black rights and white rights—it appears insoluble. As it turns out, however, there is more to "Bakke-lash" than meets the eye.

What Bakke's challenge has inadvertently accomplished is to reveal the medical colleges' embarrassing little secret: not that they are racist but that they are capricious. Standards are the least of it. Bakke was competing for 1 of 100 slots against 2,642 other applicants the first year and against 3,735 the next. If the AAMC's estimate holds, we can be sure that Bakke wasn't the only loser who was fully qualified; three fourths of his fellow rejectees also measured up. As six of the seven California Supreme Court judges noted in their majority opinion, "...the University freely admits [that] Bakke was qualified for admission, as were hundreds if not thousands of others who were also rejected."

Certain university officials have conceded that some of the slots in freshman medical classes are regularly filled on the basis of friendships and political connections. Peter C. Storandt, a former admissions officer at Davis, explained to a *New York Times* reporter that such favoritism "was an attempt to buy good will in important places"—which may have been precisely what Pope Adrian VI muttered as he granted Albert of Brandenburg a monopoly on the sale of indulgences in Thuringia.

The picture becomes murkier still when one reads the state Supreme Court's minority opinion, written by the lone dissenter, Justice J. Tobriner.

Tobriner takes the view that traditional admissions standards like aptitude test scores and grade-point averages have been grossly overrated. "Such academic credentials," he writes, "bear no significant correlation to an individual's eventual achievement in the medical profession." He cites an early study in which a certain Dr. Price found that "there was absolutely no correlation between academic performance, as measured by undergraduate and medical school grade-point averages, and physician performance." In other words, our medical schools may be screening out many of the country's best prospects; worse, by insisting on near-perfect academic records as the price of admission, the colleges may be attracting only the hotshots and grinds while discouraging others from applying at all.

The system also appears to encourage widespread cheating by pre-med students anxious to reach the Promised Land. As Alfred Gellhorn, director of the City University of New York's Center for Biomedical Education, has pointed out, science professors and students "from widely separated parts of the country...freely admit that some significant proportion of the future physicians of America have found it necessary and acceptable to pervert ethical standards to get into medical schools." (See *Change*, October 1976.) The perversions, which in some instances include the sabotaging of rival students' laboratory experiments, are part and parcel of the general defilement now afflicting medical education. Irrelevant admissions standards lead to debased behavior on all fronts. Gellhorn reminds us, for example, that pre-med students are required to get high marks in organic chemistry, "not because organic chemistry is critical to medicine but because it is a tough course that tends to eliminate large numbers of aspirants." The entire process thus becomes a wretched game, to be won at any cost.

Most of the losers remain invisible; they drop out of the race long before it is time to apply for medical school—victims usually of mediocre grades in chemistry, physics, or mathematics. Because their talents often run more to the humanities and the social sciences, these young hopefuls are deemed unfit to practice medicine. One thinks of Ashley Montague's dictum—that entrance requirements should include "the ability to care for others." Such a requirement could stir up the now stagnant admissions brew by welcoming into the profession persons who know at least as much, say, about Sacco and Vanzetti as they do about valences and atomic weights. The caring factor might also encourage medical colleges to pursue applicants with a proven humanitarian track record—students, for instance, who have already spent time working with the sick, the poor, or the otherwise benighted. In short, there is more to doctoring than the merely mechanical application of medical science; the quality of mercy must also be taken into account, and not strained out by medical school computers.

The colleges have responded to these criticisms and conundrums in a manner characteristic of besieged institutions: first, by cautiously trying to please the public without unduly undermining the profession's power base; and later, with the public still in full cry, by retreating into its institutional fortress and frustrating all efforts at reform. The relatively cooperative period occurred in the sixties, when nearly all the experts agreed there was a serious doctor shortage and when the Congress began to pay out direct subsidies in support of medical education—overcoming, at last, a half century's opposition by the American Medical Association. Between 1963 and 1973 Congress appropriated $3.5 billion for the training of doctors and nurses. At the same time, alarmed by a 1970 Carnegie Commission report predicting an acute shortage of doctors, Congress started earmarking funds for new and expanded medical schools, increasing gradually the total of first-year openings from 9,000 to 16,000. As a result, the number of medical schools has grown since 1960 from 88 to 117, and there are at least 5 more colleges "in the pipeline." Last spring the schools graduated about twice as many seniors as they were graduating during the Eisenhower era.

The optimistic formula that emerged in the sixties seemed to make sense. Medicare would emancipate the elderly from the curse of doctor and hospital bills; Medicaid would do the same for the poor; and the new medical schools, financed in large part by the American taxpayer, would supply enough doctors to meet the new demand. Alas, like most other problems perceived during those heady times, the health care riddle was too simplistically posed and its solution too timidly pursued. No sooner had the new measures been put into place than doctor and hospital fees started to soar. Congress's absurdly generous reimbursement policy, amounting to a blank check for doctors, was not an oversight; it was the price the AMA exacted for allowing Medicare and Medicaid to pass. ("How will you keep doctors from shouting down your plan to nationalize their profession?" a friend asked the British Prime Minister, Aneurin Bevan, 30 years ago. "That's easy," replied Bevan. "We'll stuff their throats with gold.")

The skyrocketing incomes of doctors triggered a medical school boom, with thousands of eager young prospects banging in vain at the college

gates; that, in turn, gave rise to the various forms of corruption and self-deception that we have already examined. It also contributed to the schools' new posture of the seventies, a stance resembling that of the palace guard with its back to the wall.

The Congress, meanwhile, in the course of supplying the medical schools with two thirds of their total revenues, continues to do what it can to lure new doctors into general practice and out to underserved areas. Last year Congress specified that about half the colleges' residencies had to be offered in primary care fields—i.e., pediatrics, internal medicine, and family practice. It also stipulated that students on federal scholarships had to work in underserved communities one year for each year they received financial aid.

These provisions may be promising, but the recent tendency of primary care physicians to specialize within a general field—in cardiac pediatrics, for instance—does not inspire optimism; and the proviso linking federal aid to postgraduate service in doctor-poor areas, if ever funded or enforced, may simply encourage schools to look elsewhere for financial support or to reduce their available scholarships. "We're dealing with a tough, aggressive profession," says a former health care aide of Senator Edward Kennedy. "They're fighting us every step of the way." Ex-Congressman William R. Roy of Kansas, himself a doctor, spent the better part of a decade trying unsuccessfully to pilot progressive medical manpower measures through the House; invariably, he ran into stiff AAMC opposition. "They're so damn hardline and inflexible," Roy told me recently. "They never negotiate."

It seems clear from all this that the ethical energy of the sixties, which brought us more doctors and better-distributed health care, is nearly played out. In most sections of the medical community it is business as usual, with the great doctor migration from country to city and from poor markets to rich markets continuing unabated. Despite the rhetoric, fewer than 5 percent of all new doctors last year chose to set up their practices in ghettos or rural areas. Furthermore, while the number of first-year positions in primary care training programs has jumped since 1968 from 4,600 to 8,000, a large majority of young doctors continues to prefer specialization—either because it is more challenging or because it is more lucrative. Forty percent of all first-year residencies and fellowships are still in surgery.

It may be that for doctors and medical educators the spirit of the sixties was simply an aberration, a flash of social idealism within a long history of fee-for-service protectionism. That history, in any case, can tell us much about today's struggles: It can help to explain why the medical clan generally prefers scientists to humanists; and it can shed light on the profession's peculiar cussedness—why it is "so damn hardline."

Most of the health care system's present inadequacies arise from its past triumphs: the advance of science, education, professionalism, and political organization. From the public's point of view, these successes have been a two-edged sword, giving doctors both the power to heal and the freedom to tyrannize. Indeed, the apparent intransigency of the medical establishment, its unwillingness to accept advice, is a consequence of the long struggle for professional status and political power.

We tend to forget how difficult and tardy was the triumph of science in medicine. Even in relatively modern times medical progress encountered strong opposition. In 1840 Dr. Oliver Wendell Holmes was unable to convince obstetricians that they were inadvertently transmitting puerperal fever to patients in lying-in hospitals. And as late as 1880 Joseph Lister's supporters failed to persuade colleagues that they ought to censure doctors who harmed their patients by ignoring antiseptics.

To further complicate matters for the nineteenth-century doctor, any business he might manage to build could be swept away by cutthroat competition. Free enterprise was rampant. Medical societies were too weak to help—the AMA, founded in 1847, had little power or influence until the turn of the century—and medical schools were too greedy to care. Most of the schools were opportunist in motive and shabby in performance. Gaining admission to one of these institutions was usually as simple as paying the tuition fee. Hardly a single novitiate had finished high school; most had dropped out of grade school.

Despite the discouraging atmosphere, some doctors began forging professional alliances, setting standards of practice, and distributing medical licenses. The new societies competed savagely for power, while the public tended to view all pleas for professionalization as ill-concealed bids to build a medical oligopoly. Those who imposed licensing and education restrictions, complained one observer, did so "ostensibly for the protection of the sick and the encouragement of medical science, but in truth, for the pecuniary benefit of a few aspiring physicians."

The benefits, however, remained appallingly sparse. It wasn't until the AMA managed to consolidate its position—by building a pyramid of medical societies from the county level on up—that the profession began to entertain any hopes of winning a measure of status and wealth. In 1878 the AMA got some help from a new group, the American Medical College Association, which met in Buffalo and called boldly for strict admissions standards and tough accrediting procedures. If any of the 160 then extant medical schools failed to meet the new standards, ran one of the wistful resolutions, then "the diplomas...of said colleges are not to be recognized."

The little group—it represented only 15 medical colleges—was certainly the wave of the future, but it soon vanished, a victim of the medical schools' vast indifference. With the exception of Harvard, Johns Hopkins, and a handful of others, most of the schools were either unable or unwilling to embrace the new association's ambitious precepts. As Dean F. Smiley, the medical historian, has pointed out, "The new organization had tried to raise standards too rapidly." Even Dartmouth demurred.

But the momentum toward scientific practice, and with it toward economic consolidation, was not to be denied. It surfaced again in 1890, this time in the guise of the Association of American Medical Colleges, a group similar in makeup and philosophy to its short-lived predecessor but wise enough now to counsel gradualism. The modern American *asclepieia* were destined to become at least as elite as the ancient Greek versions—but they would not be built in a day.

These tendencies toward professionalism converged in 1910 when the Carnegie Foundation unleashed Abraham Flexner on the nation's medical schools. Flexner was a mild social reformer with a talent for influencing robber barons like John D. Rockefeller and Andrew Carnegie. With his investigatory companion, Dr. Nathan Colwell of the AMA's newly formed Council on Education, Flexner inspected every school—some more swiftly than others. "You don't have to eat a whole sheep to know it's tainted," he snorted. The report he wrote rocked the medical world. Flexner named names and cited all manner of defects. Kentucky was labeled "one of the largest producers of low-grade doctors in the entire Union"; Chicago was called "the plague spot of the country." Few schools got off lightly. In the wake of those revelations 92 schools either merged or went out of business, and most of the others raised their entrance requirements to at least two years of undergraduate schooling. The medical colleges had come of age.

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Still, it is probably an exaggeration to credit Flexner with the revolution that followed his report; a thorough medical housecleaning was due in any case. What Flexner accomplished by his well-publicized investigation was to provide documentation and a rallying cry for the disparate forces of medical professionalism—chiefly for the AMA and the AAMC, both of which yearned for a nation of fewer but more scientifically trained physicians. Flexner and the Carnegie Commission put their seal of approval on policies already adopted by the nation's best doctors and medical schools. Henceforth, everyone would subscribe to those policies, and everyone would operate within a tight framework of AMA-AAMC controls. In this way did medical science and medical monopoly become one.

With the triumph of the AMA and the AAMC the ratio of doctors to the total population began to slide. In 1900 there were 157 doctors per 100,000 persons; by 1930 the proportion had dipped to 128 per 100,000. The reduction in competition signaled the beginnings of a seller's market in health care, allowing doctors not only to raise their fees but also to pursue a more moneyed clientele. By 1925 the AMA *Journal* was already complaining of "a universal tendency for physicians to abandon rural districts in favor of the cities." Two years later, Louis I. Dublin, the health demographer, noted a widespread feeling among the citizenry "that something is wrong with the economics of medicine. Large numbers of middle-class families chafe under what they consider the unjustifiably heavy cost."

Nevertheless, doctors continued to narrow the entranceway to their profession. In 1932, with incomes sagging and the birth rate plummeting, a star-studded, AMA-appointed Commission on Medical Education—A. Lawrence Lowell, the president of Harvard, was its chairman—proclaimed the profession to be suffering from an oversupply of doctors. "There are more physicians in the United States than are needed to provide an adequate medical service for the country," the Commission declared. The problem was not a shortage of doctors but their "uneven distribution.... There is a relative shortage in certain areas because doctors are concentrated in the larger communities." Moreover, "the number of specialists...exceeds the need."

The 1932 report signaled the AMA's now familiar position: There was no shortage of doctors but there was a geographical maldistribution of services and also a tendency toward overspecialization. The AMA would cling to this viewpoint for three decades, effectively blocking all efforts to increase the supply of doctors. It yielded, finally, in the sixties, in part because the medical schools themselves had temporarily abandoned their partnership with the AMA and were loudly calling for more doctors. "We are approaching a manpower crisis," warned Ward Darley, the AAMC's executive director, in 1959, "the most serious that medical education has faced since the Flexner Report."

If the sixties shattered the medical establishment's unity, the seventies have restored it. All parties now agree that the doctor shortage has been averted and that we are currently being haunted by that old, friendly ghost, a doctor surplus. The word comes to us by way of yet another Carnegie report. It was a 1970 Carnegie Commission, you will recall, that confirmed the shortage; it is a 1976 Carnegie Council (on policy studies in higher education) that has proclaimed the surplus. "In the face of rapid expansion in the supply of physicians graduating from existing schools," intones the Council, "we are in serious danger of developing too many medical schools." The prophecy may come as a surprise to persons living in the inner city or the outer provinces; nonetheless, it has the endorsement of powerful elements within the clan, including many medical school deans and health care analysts.

The case now being made for medical manpower containment is more sophisticated than were its forerunners; it focuses on national budgetary considerations and on a fear that too many doctors will spoil the economic broth. We are already spending $140 billion a year, or nearly 9 percent of the gross national product, on health care (goes the argument), so how can we afford more doctors? As Dr. Howard Hiatt, dean of the Harvard School of Public Health, explains it, "We're going very shortly...to be graduating twice as many doctors as we did 10 years ago. I don't think the country begins to realize that that's going to be twice as many people putting pressure on the system—ordering tests, prescribing surgery, seeking compensation." Expansion of health care, in other words, may be hazardous to our pocketbooks.

Perhaps Hiatt and others argue from cost rather than from need because dollar figures seem more convincing and less abstruse than do need figures. The latest Carnegie report devotes much space to the question of a doctor shortage versus a doctor surplus, but not once does it come to grips with the problem of need: i.e., How many more doctors will we have to train before decent health care becomes available to every American, regardless of race, income, or place of residence? In the end, the Council was content to cite the 1970 report, which pointed to four types of evidence indicating a doctor shortage. These were: exceedingly high average incomes of physicians; long waiting lines for emergency services; the long work week of the typical physician; and the rising influx of foreign medical graduates. (FMGs, as they are commonly called, now account for 30 percent of all house-staff physicians in U.S. hospitals and for one fifth of all U.S. doctors.)

The odd thing is that these four indicators of a doctor shortage are just as strong today as they were seven years ago, yet the new study has reversed the old conclusion. The casual flip-flop suggests a serious methodological shortcoming in the report: It presents no criteria we can all agree on, no reasonable way of assessing shortages or surpluses. One guesses that the conclusions were substantially in place before the study got under way. That has been the pattern with such reports ever

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since Flexner pioneered the genre.

No one, to be sure, knows precisely how to define either a doctor surplus or a doctor shortage. Is there such a thing as a just-right ratio? The United States now has about 175 physicians for every 100,000 persons, a ratio higher than that enjoyed by most other countries; yet it remains lower than those ratios prevailing in Israel, Italy, West Germany, and the Soviet Union, and the health care in those countries, if not superior to ours, is at least more evenly distributed. Israeli physicians, for example, come considerably closer than do U.S. physicians to achieving Voltaire's ideal: "paying equal attention to the rich and the poor."

In America the maldistributions of service appear to be fixed items on the health care landscape; they have been with us for at least half a century. Would it help to flood the medical market with more physicians—that is, to create a real surplus in an effort to drive some doctors into rural and ghetto practices? Or would the newly anointed doctors simply follow the older ones to Scarsdale and Park Avenue, choosing ever narrowing specialties and charging ever higher fees? We have seen how a surplus of surgeons can give rise to a surplus of surgery. No rational person would propose to generalize that error of medical marketing by assuring surpluses in the other specialties, too.

And yet...there is something spurious about this whole line of reasoning. It is predicated on the assumption that the health care network will be permitted ad infinitum to go its blithe, narcissistic way—to keep right on committing absurd extravagances and charging outrageous prices. The assumption may be correct; but scholars who bill themselves as objective analysts have a duty to present us with something more than a perpetual status quo. We need to consider alternatives to a health care system notorious for its avarice, a network whose fees have jumped 1,000 percent in a single generation.

Why, for instance, do so few in academia challenge the efficacy of the fee-for-service system? Isn't that peculiar institution, which allows doctors to tell patients exactly what they must buy and how much they must pay for it, the real source of our difficulties? Wouldn't it be more sensible to pay physicians straight salaries, as we do teachers, soldiers, postmen, and politicians? I do not suggest that the national health care puzzle will yield to easy answers, only that our scholars have failed to ask the tough questions; and in the process they have casually written off millions of medically starved Americans, in the name of a doctor surplus that may not in fact exist.

It is difficult to escape the conclusion that doctors and medical educators are still pushing their old agenda—the one they invented in 1847, imposed in 1910, and reaffirmed in 1932. "A surplus of physicians," notes the 1976 Carnegie Council report in a remarkably candid passage, "would probably not manifest itself in unemployment among these highly trained professionals but rather in some *decline in their average incomes...*" (emphasis added). There you have it, the profession's operational definition of a doctor surplus: a competitive situation in which doctors' incomes decline. But this may be one kind of surplus that the public wants.

If congressional activity is any indication, then it seems fair to say that the public wants *something* but doesn't yet know how to define or demand it. The hopper is overflowing with reform measures—not only the perennial medical manpower bills but also an ever-mounting stack of proposals for national health insurance. The two categories, of course, are closely related. It stands to reason that enactment of universal health insurance—an "inevitability" that experts have been predicting for half a century—will have a profound effect upon the medical profession. More doctors will be needed to serve those who for the first time may have the means to buy health care; and, in face of the new demand, more controls will be required to prevent a fresh round of inflation.

Yet few of the bills extant confront either of these questions. Like the analysts and lobbyists who wrote them, they assume that doctors will continue to call the shots on all major manpower issues, including the number of available physicians, their choice of locales, and the size of their fees. Only two of the current measures—one offered by Senator Kennedy (the Health Security bill), the other by Representative Ronald Dellums (the National Health Service bill)—envision a system in which such decisions are made outside the profession; that is, by the public. And neither of these seems destined for early enactment.

This society, then—especially its white, middle-class segment—faces a hard choice: It can persist in its pursuit of immortality, merely pressing for broader insurance coverage and a more sophisticated medical technology and merely getting a more remote and expensive health care system; or it can renew its sporadic quest for equality, insisting that thousands more doctors be trained and dispatched to all corners of the land, there to sell federally financed health care at prices the nation can afford. Who is to say which direction Americans will finally choose? The rumble of Zeus's thunder can now be heard, but it remains too distant to decipher. ■