

## 2. A Dilemma for Medical Education Reform: Form versus Content

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**T**HE HISTORY OF ATTEMPTS TO MATCH THE SUPPLY of physicians to the needs of health care in the United States—whether by regulation or by market forces—has not been marked by success. This gives me a cautious feeling as I read the essay by Fitzhugh Mullan and colleagues (1994), despite the fact that I share the belief with many others that it is necessary to actively increase the supply of generalists. James Thurber summed up the problem in a fable. He tells of a “fairly intelligent” fly who wisely refused to land on a spider web because there were no other flies on it, lighting instead on a piece of flypaper crowded with flies because he assumed they were dancing. His moral: “There’s no safety in numbers, or anything else” (Thurber 1939).

The basic problem with the analysis, and others like it, is the assumption that the genesis of the change in the mix of physicians to the new 50/50–110 proposal formula is, in fact, based on the grounds given by the authors: that the current oversupply of specialists at the expense of generalists fails to meet the problems of the undeserved as well as playing a part in the escalating cost of healthy care. These reasons, while they may be true, are merely more obvious pieces of evidence (especially interesting to policy makers) of the continuing evolution of the whole system of medicine over more than 150 years. The proposal may result in

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producing more generalists, but failure to take account of this history will not bring about basic changes in the practice of medicine on which the health care system is founded, and thus current problems will remain unsolved.

Historically, ours is disease-oriented medicine. This means, in general terms, that when someone is sick doctors expect to find a disease as the cause of the illness (pneumonia, coronary artery disease, multiple sclerosis, diabetes, and so forth). Treating the sick person means intervening in the mechanism of the disease; prevention (in these terms) means acting to prevent the disease from getting started or making the person sick. The wonderfully successful growth of medical science has been directed toward understanding the mechanisms of disease down to their most basic, molecular level and devising interventions based on this knowledge. The ever-growing profusion of medical technology is in support of the same purposes. The education of physicians from the beginning of medical school to the end of postgraduate training is based on the same marvelous science and technology. Its reductive dependence on specialists and technology, however, makes it inherently expensive. Not surprisingly, modern medicine grew up in the high-technology, big-science social environment of this century amid a population captivated by scientific and technological "fixes" for problems and willing to pay for them. As a consequence, this kind of medicine developed a devoted public with a seemingly unending appetite for its product.

As everyone knows and many have been talking and writing about for at least two generations, sickness is incompletely, and often inadequately, explained by disease and its pathophysiological mechanisms. Social and psychological factors may loom larger in the production of sickness than the disease that surfaces at the end of the process. Witness, for example, the largely unexplained, but always demonstrable, excess burden of sickness borne by the disadvantaged. In addition, modern medical training and the present system of disease medicine performs poorly in the care of chronic illness, the disabled, and many of the problems of the aged. Although all of these difficulties with disease and specialist-oriented medicine are well known (even to medical educators), this knowledge has had remarkably little impact on the core of graduate and postgraduate medical education. There are signs that it is receiving attention in medical schools: the burgeoning of medical ethics courses, the addition of departments of humanities in some schools, as well as

courses in compassion, more stress on the doctor-patient relationship, and such like. Most awareness, however, is still peripheral.

Outside the academy, things are different. Patients remain enamored of high-tech specialty medicine (they know no other), but, for example, they want to be treated as persons, not containers of disease, they want doctors who talk to them, they want to be active participants in their care, they believe in prevention (although confused about what it really means), they do not want to be merely kept alive in terminal illness. In addition, payers are a force for change; witness the purported goals of managed care cost containment in all its forms (HMOs, PPOs, POS, to name a few). There are contradictions, of course, as is characteristic of transitional periods, but the general push in society is toward a different kind of medicine. Different medicine means doctors who do things differently because they are trained differently. Thus, one would expect that, given enough time, these evolutionary forces for change would, in themselves, push generalism to the fore and that the specialist generalist mix would change.

Into this general path of change (which can be traced back at least 60 years) comes the 50/50-110 proposal based primarily on economics and politics and seemingly indifferent to the social history of the matter. An example of "the cunning of reason," Hegel would say, referring to the underlying rationality of the universe asserting itself.

I believe the 50/50-110 formula can be a big step forward, if . . . . The "if" depends on what these generalists will do: What kind of medicine will they practice? What kind of doctors will they be? Mullan and colleagues do not specify what generalists do, and neither does a recent health policy report on the same subject that appeared in the *New England Journal of Medicine* (see Iglehart 1994). In fact, the literature on primary care, despite the recent surge of interest, does not provide a clear understanding of what a generalist is. The transition of the profession from its previous era will continue if generalists are trained to focus on the sick (or well) person, which is the mandate of social history of much this century, rather than primarily on the disease. For this to happen, new directions will be required in training programs for generalists that specifically provide them with the knowledge and skills that are the basis for doctoring in their expanded role—taking care of sick and well persons, including the chronically ill, aged, and disabled—and are as essential as knowledge of disease and medical science. This kind of educa-

tion can move them past overdependence on expensive technology and specialist referrals—and only explicit training will do that.

If, on the other hand, the effect of the regulation of physician mix and supply is to provide a large supply of relatively inexpensive gatekeepers and high-volume first-contact doctors trained in the current mode, then the richer practice of medicine, which is the *natural* outgrowth of the evolution of medicine, will be delayed. In addition, overutilization of specialists and technology will continue, assuring the escalating cost of care. At issue is not merely the mix of specialists and generalists, but also the health of the medical profession (and the population) in the United States for the next generation.

Too many people, including policy makers, legislators, and corporate executives in and out of the insurance industry, are still ensnared in the mythology about the profession, characterized, for example, by rich doctors, a powerful AMA, the best medicine in the world. Look around at the medicine of the country. Not in the fancy big centers or at front-page advances. But in everyday offices and hospitals. Don't gauge medicine's efficacy by death rates—that is not how you would measure the health of a family or community. Over a couple of beers, survey recent graduates about their values. Then ask yourself what your values would be if you were 25 years old and had a \$70,000 debt. I believe, if you do this, that the scales will fall from your eyes. Then ask yourself what you want your doctors to be: high-class health technicians or scientifically based healers? What do you think should be the ideals of the profession, of recent graduates, and of practicing physicians? What should the salary of a new practitioner be? of a long-experienced physician? How should excellence be rewarded? When these questions have been answered, then speculate what structure of American medicine will meet your goals and how this kind of medical profession is to come about.

The recommendations by Mullan and colleagues address one very important aspect of the future medical landscape of the United States. Theirs, and many other recent proposals that have emerged from the exciting leaven of coming health care reform, is about the form medicine will take, not its content. As though the content will take care of itself—it never does. As we proceed with changing the mix and number of physicians, we should remember that it is not the number and kinds of doctors that are being changed, but the medical profession of the United States for a generation to come.

