The Future Of Medical Education: A Call For Action

A privately funded, nonpartisan commission would be a good way to begin to address current and future problems.

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ABSTRACT: The challenge of building new medical schools or expanding the class size of current ones is a lengthy and costly enterprise. That reality argues for the creation of a national vision about how to proceed and what to prioritize, a vision that could serve as a map for public and private officials considering further investment in medical education. A national commission funded by one or several health philanthropies is suggested as an expedient vehicle to focus this discussion and move the debate forward. Instructive educational innovations in osteopathic and nursing education are suggested as germane to the deliberations of a national commission, as are creative means of student funding.

AMID THE MANY thoughtful and provocative observations made by Richard Cooper in his commentary on the history of U.S. medical education, one stands out as especially problematic. Building new medical schools or expanding old ones requires a great deal of time and money, a lesson that has often eluded health policymakers and medical educators in the feast-and-famine cycles of the past century of growth. What, this observation calls to us, are we doing about the future?

A National Deliberation

Whether or not one agrees with the dramatic projections for the increased demand for physicians that Cooper has published previously, the effort to calculate future demands based on population growth, emerging technologies, and evolving patterns of practice invites the reader to contemplate a time when current medical school capacity will not suffice. Strong evidence exists that, in fact, the problem is here already. U.S. medical school capacity today does not begin to meet current needs—let alone future ones—since a quarter of the positions in graduate medical education (GME) and a quarter of practicing physicians today are graduates of medical schools elsewhere in the world. We have buffered the shortfall in U.S. medical education by the extensive use of international medical graduates (IMGs) for a quarter-century, during which time allopathic medical education has maintained a static number of medical school enrollments. Along the way we have turned away thousands of U.S. applicants with excellent credentials because space is lacking. Although osteopathic medical education has grown over this period, allopathic medicine has not, and only recently has the Association of American Medical Colleges (AAMC) indicated a willingness to consider the advisability of building more medical schools.
The substantial investment of resources necessary for a major expansion of U.S. medical education will not happen without a national consensus regarding the growing needs of the system as well as the importance of creating more opportunities for young Americans to study medicine. Building such a consensus will require buy-in from the public, from medical educators, and from policymakers at the state and federal levels. It also could create a potent opportunity to consider strategies to address chronic imbalances in areas such as minority enrollment, geographic distribution, and specialty emphasis in U.S. medical education. Government should certainly play a part in initiating these deliberations, but the U.S. philanthropic community is well positioned to play a leadership role in stimulating the discussion and helping to craft consensus. The Carnegie and Rockefeller Foundations played historical roles in the transformation of medical education initiated by the 1910 report of Abraham Flexner. Numerous private philanthropies helped stimulate the growth of medical education in the 1960s and 1970s, including the Commonwealth Fund, the Josiah Macy Jr. Foundation, the Carnegie Corporation, and the Robert Wood Johnson Foundation.4

To stimulate and focus the needed debate, one or several foundations working collaboratively could fund a national commission to study possibilities for the expansion of medical education including the financial, educational, and policy ramifications of a national initiative. The deliberative process itself would do a great deal to stimulate discussion, and the commission’s findings could have tremendous impact on public opinion, legitimizing certain priorities for growth and suggesting strategies for expansion.

Creative Thinking

■ Pragmatic success of current model. A national deliberation on the expansion of medical education would present an opportunity to consider possible variations on the traditional model of medical education—a model notable for both its lengthiness and its tight connection to medical centers engaged in other complex missions. Osteopathic medical education, for instance, has grown rapidly over the past decade, opening five new schools (a 33 percent increase). Four of the five are private. All are tuition driven, focus on education, and have neither teaching hospitals nor large research portfolios.5 They all emphasize primary care, and their graduates do well on both osteopathic and allopathic certifying exams. The pragmatic success of this model of medical school expansion needs to be considered as an option for opening new medical schools.

■ Length and structure of training. A second area that deserves attention is the length and structure of today’s medical training. To the four years of “undergraduate” medical education that were the norm of the early twentieth century have been added three to seven more years of “graduate” medical education (residency), depending on the specialty being pursued. In 1988 Robert Ebert, dean emeritus of the Harvard Medical School, and Columbia University health economist Eli Ginzelberg argued that medical education had become unnecessarily lengthy. They proposed that specialty students enter residency after three years of medical school and that the primary care disciplines merge the last two years of medical school and the first two of residency, shortening the length of training for everyone.6 While this model generated much discussion and a few cautious experiments, it ultimately had little impact on the well-grooved paths of traditional medical training. Recent data suggest that with proper training, experienced nurse practitioners can work as clinical providers on a par with physicians; this raises the possibility that other avenues of education exist through which “doc-
tors” could be trained. This, in turn, reinforces the idea that innovations in education might well enrich and streamline medical training and should be part of any national conversation on the expansion of medical education.

**Impact of high tuition.** Any review of the future of medical education should take into account the impact of increased tuition (current average, $31,000 in private schools and $15,000 in public schools) and debt burden (current graduating average, $99,089) on medical practice. Might it not be timely to consider a national subsidy for medical tuition to lower barriers to enrollment? What about the expansion of service-conditional student support such as the National Health Service Corps (NHSC) or the National Institutes of Health’s (NIH’s) Loan Repayment Program for Health Disparities Research? Might it not be worth considering combining the Armed Forces Health Professions Scholarship Program, the NIH disparities program, and the NHSC into an expanded national medical-education-for-service program?

The Need To Move Ahead

All of these issues would be on the table of a national commission whose job it would be to make recommendations for public and private investment in medical education. What seems clear, however, is that if we do not move quickly and creatively to anticipate the inevitability of the need for more positions in medical school, one outcome is likely: Congress, responding to increasing demands for doctors, will follow a well-established—if not always acknowledged—shortcut by raising the funded Medicare GME cap, thereby creating an incentive for the training of more physicians at the GME level. If there are no additional U.S. medical school graduates, we will turn to the world again, offering ambitious physicians from largely poor countries entrée into U.S. GME, swelling the already substantial presence of IMGs in the ranks of U.S. medicine. Events unfolding in this manner will not provide more Americans with the opportunity to study medicine, nor will they be seen as responsible global citizenship by a wealthy nation endowed with a tradition of excellence in medical education.

We need to begin active deliberation about creating growth opportunities in medical education. A privately funded, nonpartisan commission would be the way to launch that discussion.

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