MEDICAL SCHOOLS AND THE PUBLIC INTEREST: A CONVERSATION WITH ROBERT G. PETERSDORF

by John K. Iglehart

Prologue: Amidst the world of turbulent change that marks American medical care, one sphere stands out in its capacity to maintain its traditional ways: medical education. Ironically, its new national spokesman, Robert Petersdorf, president of the Association of American Medical Colleges (AAMC), has always been an outspoken voice for change in medical education. Petersdorf's expressions, regarded over the years as heretical by some of his academic medical colleagues, have not prevented him from becoming one of this community's most esteemed members. He has been awarded nine honorary degrees. Petersdorf also has enjoyed a varied career in academic medicine as a department chairman (internal medicine, 1964–1979) at the University of Washington's School of Medicine, as a president of a Harvard University teaching hospital (Brigham and Women's, 1979–1981), and as a vice-chancellor and medical school dean at the University of California, San Diego (1981–1986). Petersdorf was appointed president of the AAMC in 1986, replacing John A. D. Cooper. Their leadership styles are quite different. Cooper was an imperious advocate of academic medicine and biomedical research, an attitude that wore thin on Capitol Hill over the years. Petersdorf, on the other hand, has sought to reopen channels long corroded by Cooper's "we know best" attitude. As a consequence, the association's relations with Congress have improved immeasurably in the past eighteen months. For example, two key Democratic legislators—Henry A. Waxman and David Obey—with whom the AAMC had cool relations during Cooper's reign, recently addressed separate meetings of the AAMC's board. Petersdorf travels a lot, devoting greater attention to the views of the AAMC's disparate constituency of medical school deans, teaching hospital chieftains, and academic department chairs. He also is placing a renewed emphasis at the association on encouraging medical schools to strengthen their efforts to enroll minorities.
Medical Education Reform: The Ebert-Ginzberg Proposal

Q: Robert Ebert and Eli Ginzberg have put forward in their proposed reform of medical education a prescription that some consider impractical, others view as too radical, and still others regard as moving in appropriate directions. Cite, if you will, what you regard as the weaknesses and the strengths of the Ebert-Ginzberg paper.

A: The major proposal is the consolidation of two years of graduate medical education with four years of undergraduate medical education to make a six-year program. This is an interesting idea that is basically sound. The fourth year, as we now have it, is not well-structured and often is wasted. If we produce a more meaningful and more structured fourth year, then we can put together a six-year program of medical education and graduate medical education (GME) that would enable us to graduate an undifferentiated primary care practitioner. It would certainly save a year. In fact, it also might lead to a more meaningful collegiate experience, rather than the stultifying premedical curricula that currently exist in many colleges and universities. However, there are a number of difficulties in implementing the proposal, primarily because GME is separated from medical education by a distinct border; it is like moving from one country into another, not only intellectually and conceptually, but also physically. This physical movement, of course, would come to a halt if the Ebert-Ginzberg proposal were implemented. This would be a major change, because today GME is a fairly autonomous system. In fact, many of us now feel that it is not sufficiently accountable. For example, certifying board requirements are being changed without attention to cost or needs of the public.

Q: When you talk in this context of board requirements, are you talking about lengthening the training period?

A: That is correct. I am talking about extension of training periods and time, and, in some instances, new areas of recertification or special competence. I am not opposed to that, but I think too often the training periods are lengthened—for example, cardiology recently added a year—without due regard for where the resources for that additional year are going to come from. The point that I want to make, however, with respect to the Ebert-Ginzberg paper, deals with the fact that in implementing their recommendation, you have to bring two years of graduate medical education, which currently take place outside of institutions, into the medical school—at least for administrative purposes. GME is a private-sector enterprise, which depends on the interaction between the certifying and accrediting bodies and the program directors in our hospitals, and which has little to do with medical schools. When residency program
directors function in that role, they take off their faculty hats; they have a
different title, and they perform a different function. In fact, many
faculty in clinical departments place much more value on their graduate
medical education programs, such as residencies and fellowships, than on
teaching in the medical schools.

What Ebert and Ginzberg are suggesting is that two years of GME—
what are now postgraduate years one and two—be brought into the
medical school as years five and six. That is a major shift in emphasis, and
it also means that a very complicated system has to be reoriented in a
major way. That is why many people say that the authors’ proposal is not
practical. I would not go so far; I would say that it is worth trying with a
few schools and hospitals that can work together. It also may take a good
deal of financial support. We want to be sure that an idea that may be
inherently good does not die for want of proper resources.

Q: Do you assume that this body of thinking, put forward by Ebert particularly,
stems in large part from his experiences at Harvard, where the dean of the
medical school essentially controls only the first two years?
A: I do not know. I often speak on various issues dealing with medical
education, and while I do not go as far as Ebert and Ginzberg, I do suggest
that the fourth year have fewer electives and less travel to look at
residencies. If we were to make it the equivalent of a good rotating
internship, it might cut off a year of graduate medical education, which
seems to be getting longer and more expensive. My proposal would be
much easier to implement than that of Ebert and Ginzberg. Moreover, if
subsequent training also were carried out in the same institution, the
coordination would be better still. Moving from institution to institution
would have to be sacrificed, but then that is not occurring nearly as often
as it used to in the days when nobody was getting paid and most people
were unmarried and did not have families. The major move nowadays
occurs between medical school and residency. What Ebert and Ginzberg
suggest is that nobody moves for six years and that you move at the end of
the sixth year. I suggest that it may not be necessary to move at all, or to
move directly from the postgraduate year four into residency.

One other issue with the Ebert-Ginzberg paper is that the primary care
specialties have mandated a graduate curriculum that takes three years
rather than the two Ebert and Ginzberg suggest. The three-year training
period is a major change for family practice, which used to require only
one year of training. That specialty realized that they could not teach
what they felt they needed in one year, and went to three. In internal
medicine, there would be a major squawk if you turned out internists in
two years; many people are saying that four years are needed because of
the breadth of knowledge to be acquired. These specialties (internal
medicine, family medicine, and pediatrics) will look at the two-year proposal as a downgrading of the generalist. I, too, think that this is a negative aspect of the proposal.

On the other hand, if we could create a consortium experiment, we might consider training a more global primary care physician competent in medicine, pediatrics, and some parts of family medicine, and do it in four years. There are combined programs in medicine and pediatrics now that are very popular. In this modification of the Ebert-Ginzberg proposal, the first two years would produce an undifferentiated, licensable physician. Add another two years and you would have a primary care specialist. Alternatively, a two- or perhaps a three-year period of subspecialty training would result in an internal medicine system-oriented specialist. This tracking procedure would result in a physician who is either a specialist or primary care physician, but not both. Surgeons would do three additional years after the initial two. I contend that if the surgeons spent the first two years learning medicine, some pediatrics, and the fundamentals of surgery, it should not take more than an additional three years to pick up the techniques of surgical practice. Of course, really high-tech surgery, such as cardiovascular surgery, would require additional training, but there are limits on how many more cardiovascular surgeons the market can absorb.

Reagan Administration Policies

Q: Generally speaking, the Association of American Medical Colleges (AAMC) has not been very enthusiastic about the health policies of the Reagan administration. What does the association take the greatest exception to regarding these policies as they affect medical schools and teaching hospitals?

A: Let me say at the outset that the AAMC does not oppose many of the administration policies. We take positions on legislation and comment on regulations. In the future, when I speak to this issue, as well as to the topics I have addressed so far and any further questions you might ask, I am speaking as president of the AAMC, but I am not speaking for the AAMC. This may be a fine distinction, but it is very important.

With this as a preamble, I would say that the teaching hospitals and medical schools have done reasonably well under the Reagan administration, perhaps despite and not because of its policies. If we place these policies into three major arenas—student assistance, biomedical research, and reimbursement for clinical services to hospitals and physicians—I would say that during the past eight years, the most negative aspect has been curtailment of loan and scholarship programs, particularly the latter. We are not alone in deploving this; all student loan and scholarship
programs, including those of all the health professions, have been cut. This means that many of our graduating medical students enter graduate training and/or practice with a very large debt, often in excess of $100,000. While some, such as economist Uwe Reinhardt, have argued that this is a good investment, it seems clear that the anticipation of a large debt keeps some young people out of medicine altogether.

I also am concerned that student indebtedness or, to put it in the converse, anticipation of future income affects career choices. For a future neurosurgeon with an anticipated annual income of $200,000 or more, medicine may be a good investment; for a family practitioner who can expect to earn $70,000 a year, this is much less the case. I contend, therefore, that indebtedness may drive individuals into specialties that already are overcrowded. There are little hard data on this issue, but it is my gut feeling that I am right. There must be some reason why so many people want to be orthopedic surgeons or ophthalmologists.

Q: Do you think the linkage between specialty choice and student debt will continue to strengthen?

A: Yes. Even if the data on this point are not hard, I think there is a definite linkage between anticipated income and career choice. One ailment of our health care system that we have not come to grips with is the progressively greater variation in physician income. The range is enormous. We talk about a median income of $120,000, but it is brought to that figure by a significant number of high-earning physicians, leaving at least half earning considerably less.

Let me now turn to research. In the face of parsimonious funds for research by the administration, Congress has acted consistently to increase National Institutes of Health (NIH) appropriations. As a consequence, research funds have risen. The problem as I see it is that there are more and more qualified applicants for these funds. As a result, an increasing number of applications are being approved but not funded. For example, the word is out in my old fraternity, infectious diseases, that one needs to be working in acquired immunodeficiency syndrome (AIDS) to get funded. In general, the academic community has not done badly, but growth has not been commensurate with the talent available. Perhaps we should place a ceiling on what we can spend on research and development (R&D), but compared to our overall health care expenditures, we spend relatively little on R&D. Perhaps we should spend more.

The third policy about which you asked has to do with reimbursement. Our agenda is the proper payment for hospitals and the maintenance of graduate medical education. I must say in all honesty that we, the teaching hospitals, have done better than expected. It is likely that boon is coming to an end. Although most of the teaching hospitals have
maintained a black bottom line, the magnitude of the surpluses is
decreasing every year. We also are concerned about the maintenance of
the indirect medical education adjustment. It remains at a reasonably
good level (7.7 percent for fiscal year 1988), but we can thank Congress,
not the administration, for that. Indeed, if some of the proposals of the
administration had come to fruition, the teaching hospitals would be in
deep trouble.

Q: Let me ask you another question within the context of Medicare support for
graduate medical education. Even though, as you point out, the teaching
hospitals have done well to date, the trend, in terms of Medicare support, is
down. This raises the question, in my mind, “What is the rationale of Medicare support
for graduate medical education at all?” Undergraduate medical education is not
supported in a similar fashion, not to mention schools of architecture, law, and
other graduate training programs.

A: Graduate medical education is supported simply as a cost of doing
business. There is a cost in caring for patients, and the Medicare law was
founded on the principle that hospitals would be reimbursed for these
costs. When diagnosis-related groups (DRGs) came along, this principle
was altered, but inasmuch as graduate medical education contributes to
patient care, it should be a reimbursable expense. I also can argue that
physicians are a national resource or that medicine is a quasi-public
utility. In that sense, it deserves support.

The Training Of Medical Professionals

Q: Another issue concerning the way residents are trained deals with their duty
hours and supervision in teaching hospitals. Specifically, New York State has
taken the lead there in calling for shorter emergency room shifts and sixteen-hour
shifts on the wards as a maximum, separated by at least eight hours off, and
restricting moonlighting. Several other states, I believe, also are considering
similar restrictions. As I understand it, the AAMC has moved aggressively
under your leadership to embrace these changes. Explain, if you will, the positions
of the association at the current time and the way it is evolving.

A: Rarely have I or several key members of our staff spent as much time
on an issue. Our constituents are intimately involved, and everyone
thinks they have an answer. When this whole business began last sum-
mer, I was very much on the side of the establishment, but in looking at it
more closely, I have come to the conclusion that we do need some reforms
during the first two years of graduate medical education, particularly in
internal medicine, surgery, pediatrics, and obstetrics/gynecology. Be-
cause it has been so difficult to come to a consensus, the AAMC has not
come out with a position to date, although we hoped to have done so by
the end of February 1988. We also hope that our position will be balanced and flexible, will take into account the diversity of our graduate medical education system, and will not focus solely on hours. The only statement we will make about hours is that working hours should not exceed eighty hours per week averaged over four weeks. We have not insisted, as have the New York State regulations, on an eight-hour period off after a twenty-four-hour period on, because this is likely to interfere with the educational process. Likewise, while we approve of the resident’s having at least one day a week away from the hospital, we do not think this should be spelled out rigidly, particularly because it is common practice on some services to make rounds on Saturday or Sunday morning. To me the most important issue is supervision, and I am afraid that in some programs—and it is by no means uniform—we have not done the best possible job in supervising the housestaff.

Many of the issues addressed by the New York State regulations are not applicable to other parts of the country. For example, both at the University of Washington and at University of California, San Diego (where I worked previously) there have been full-time emergency physicians for at least a decade. That is true for many other institutions as well. It is true that the pace of many housestaffs now is much more hectic than it used to be. There are many reasons for this, including new technology, more rapid turnover of patients, and the number and complexity of procedures. We must find a way to mitigate these stresses without scrapping the entire system of graduate medical education, which is fundamentally sound.

Q: Over the years, you have distinguished yourself in a variety of capacities, such as teacher, researcher, administrator, and commentator. I would like to concentrate on this last role by asking you to comment on some of your previously published remarks regarding America’s academic health centers. For example, you wrote in The New England Journal of Medicine in October 1983 your future prescription for ensuring the viability of academic health centers. You wrote: “My formula for survival of the academic establishment is as follows: (1) Emphasize quality and not quantity. (2) Go on a manpower diet, reduce the size of medical school classes, close some medical schools altogether, and cut graduate training programs accordingly. (3) Accept two types of faculty: researchers and clinicians. Both groups need to teach. (4) Dissuade the university and its faculty from the notion that everybody is an investigator. (5) Restrict research to areas in which there is a critical mass, a high level of technical competence, good support, and the ability to compete. There is no need for every medical school to cover the investigative waterfront. (6) Consider arrangements that obviate university ownership of hospitals. (7) Initiate and operate effective group practices run by professionals, not necessarily department chairmen or deans, and be prepared to
compete for private patients to develop patient bases." And you concluded that particular sounding board, entitled "Is the Establishment Defensible?," by saying: "In 1971, when I defended the establishment, I felt good about it. In 1983, I have trouble defending an establishment that, while retaining some of its strengths, has failed to recognize and cope with its weaknesses. I would like to have us collectively consider some of the reforms I have suggested, so that by 1995 the establishment will again be defensible."

I'd like to ask your opinion on several of these tenets that you expressed in 1983, starting with your assertion that academic health centers should emphasize quality, not quantity. Let me take that a step further by noting that in the mid-1970s there were twenty-eight applicants for every ten places in American medical schools. There were only about seventeen for every ten places that entered in the class of 1987. Yet there have been only modest reductions in the total class size. Assuming that this is one of the dimensions of the "quality over quantity" argument, have U.S. medical schools reached a critical point at which there are too few qualified applicants for the 16,000 or so available first-year places?

A: I do not think so. I obviously was younger and perhaps more impetuous when I wrote that, but we do have some data on this particular issue. The fall-off in Medical College Admissions Test (MCAT) scores and grade point averages (GPAs) has been very modest, with GPAs showing almost no decrease and MCAT scores showing only minor fall-offs, mainly in the hard sciences (chemistry and physics). Part of this may be attributable to demographics of our applicants and acceptees, which has changed to more women, who perform better in the humanities and biology, accompanied by a sharp fall-off in white men, who traditionally have been the strongest in the hard sciences. Certainly, the qualifications of applicants have not decreased to a dangerously low level. It is by no means clear that a young person who is admitted to medical school with a GPA of 3.4 is less able to succeed than one who has a GPA of 3.6. The same might be said for MCAT scores. There also is some evidence that the fall-off in applicants may be reaching yet another plateau. Based on decreases in 1985-1987, we predicted a drop of another 10 percent for 1988. It does not look as if that will happen; the drop is likely to be between 3 and 5 percent.

It has been suggested that the October 19 stock market meltdown may be responsible for the flattening of the line. Perhaps students now think that medicine is a "safer" career than business. It is certainly true, however, that medical schools have been much slower in cutting matriculants. These have decreased at a rate of about 1 percent a year, not nearly as much as the number of applicants. It may be that in years to come, even with a slower fall in applicants, acceptance-to-matriculant ratios may fall to 1.3 or 1.4, and that may mean that less-qualified individuals are
entering medical school. The medical schools then will have to decide whether there has been sufficient diminution in quality to decrease class size more radically. It is my personal opinion—not the AAMC position—that the ideal number of entering medical students is somewhere between the high of nearly 17,000 and the low of 9,000 (the level when the present acceleration began). If I were employing zero-based planning, I would suggest 13,500. There are some people, however, who listen to Reinhardt and who would flood the market to drive physician income and health care costs down and to improve access. Apparently that is what has happened in Germany. I do not particularly want to see that. When you work as hard and as long to get where you are, and when people with much less schooling are making $45,000 a year, why shouldn't physicians make $100,000?

Q: Let's assume that 13,500 or so medical school graduates is the right number in the 1990s. What role do you anticipate some of these interests that are involved in sufficient supply will assume? For instance, consider the AAMC's task force on physician supply, the Council on Graduate Medical Education (COGME), individual states, the federal government, or medical schools. How do you see this coming to bear, if indeed we are going to reduce the production capacity?

A: Whether production capacity is likely to be reduced is very controversial, and its reduction is not currently the AAMC position. We will need to await the outcome of our physician supply study, which I hope will be available in 1989. COGME has said that there is an oversupply but that it does not seem to have any adverse consequences. To me that is an oxymoron; by definition, oversupply means that the effects are negative. In the Summer 1987 issue of Health Affairs you published a dialogue between Ruth Hanft and me. She took the position that there will always be plenty for doctors to do, and therefore we should be producing more to remedy the failures in access and care for the poor or otherwise socially disadvantaged. I agree that these are severe problems, but as I pointed out in my rebuttal, physicians will not opt for specialties or places to practice if they cannot make a decent living. We have seen this clearly in dentistry. There is certainly an ample supply of dentists and many remaining dental problems, but dentists have not opted to practice in sites of need where they could not make a living.

My present thought on physician supply is that we can model the supply side quite accurately, but that projections of demand/need are very murky. In retrospect, we probably expanded too rapidly when the number of medical schools was increased from eighty-five to 127 and the number of entering students from 9,000 to nearly 17,000, but it is always easier to expand than to contract. We also must not ignore the osteopathic schools in the equation. They have doubled their output, a
salutary phenomenon because so many osteopaths turn out to be primary care physicians. In contrast, more than 50 percent of the graduates of allopathic schools turn out to be specialists and subspecialists. I do think that there are serious problems inherent in the oversupply of the subspecialists, the recent paper by Schwartz and his colleagues notwithstanding [W.B. Schwartz et al., “Are We Training Too Many Medical Subspecialists?” Journal of the American Medical Association (8 January 1988): 229–232]. To get back to your original question, perhaps we do not have to lose as much weight as I originally suggested. We should just lose it in the proper places.

Q: So, translated, you’re saying fewer subspecialists?
A: Fewer subspecialists and more general physicians.

Q: How would you do that? The payment mechanism?
A: Payment mechanism is certainly an effective way to alter the specialty mix. Legislation has been suggested (but not passed) to restrict the employment of foreign medical graduates (FMGs). It turns out that more FMGs become specialists than generalists. There also needs to be a balancing of physician reimbursement. We all are awaiting Bill Hsaio’s study, which almost surely is going to suggest better reimbursement for cognitive services that are provided by generalists and reduced reimbursement for the procedure-oriented specialties and subspecialties. However, unless physicians and insurance carriers alike buy into the Hsaio recommendations, they will not mean a thing. The fact remains that the income potential for specialists and subspecialists is much greater, and unless this basic inequity is corrected, we will not be able to address the imbalance between specialists and generalists appropriately.

Q: What you appear to be saying, in relation to the federal role, is in fact something that has been articulated in the past by such influential members of the academic medical establishment as Arnold Relman of The New England Journal of Medicine and Robert Heyssel of Johns Hopkins: that the government must become involved in influencing the distribution of residency training positions in the U.S., albeit in the least intrusive way possible.
A: I said it, too, but I am not terribly happy about it. I am afraid that market forces are not controlling residency selection very well. Some are saying that the market will control. Yet they have been saying this for more than a decade, and I see no diminution in individuals opting for specialty residencies and fellowships.

Physicians And AIDS

Q: The Association of Medical Schools of New York State recently approved a policy stating that any faculty member, hospital resident, or medical student who
refused to treat an AIDS patient at any of the state's thirteen medical schools would be dismissed. The policy declares that physicians have a "most fundamental responsibility" to treat AIDS patients. What is your opinion on this new policy? Should the AAMC adopt a statement in this area?

A: The AAMC has a committee on AIDS that is progressing very well. I am in agreement with the New York State position. It is in concert with the feeling that there is risk inherent in medicine. Actually, this risk is lower for AIDS, which is not readily transmissible, compared to tuberculosis and other infections that were prevalent thirty or forty years ago.

Access To Medical Schools

Q: Increasingly, there seem to be have and have-not medical schools and teaching hospitals, depending on their history, location, the students they attract, and the patients they treat. Are these dichotomies growing more sharp, in your view? And what does that foretell, if that is so? More specifically, minority medical enrollments have been declining. What should be done on that score by schools and government?

A: Let me answer this by pointing out that there are wide variations in medical schools. However, they all have met standards for accreditation; they do vary in quantity and quality of research, their approaches to clinical teaching, the size and strength of their faculties, and so on. With respect to minorities, their number is not declining, it is simply at a plateau. We need to do better here.

Q: Is the complexion of minority enrollment changing? For instance, are you getting more Asians and Filipinos and fewer Hispanics and blacks?

A: The AAMC's definition of minorities is very strict and includes only blacks, Hispanics, Native Americans, Mexican Americans, and mainland Puerto Ricans, and not Asian immigrants. The latter group is competing very well for admission to medical school. The issue for underrepresented minorities is the very high cost of medical education, and we need to find a way to give them better support. Many of them are not choosing medicine because of the length and difficulty of the educational process and its high cost. Why become a physician when a college graduate can command a job at $30,000 or $40,000?

Medicare Support For Training FMGs

Q: The AAMC has adopted a policy that favors the termination of Medicare support for the graduate training of FMGs. What is the association's position regarding the provision of patient care for those individuals and teaching hospitals who depend on foreign-trained physicians?
A: Our position on the financing of graduate medical education is that there should be a gradual reduction of FMGs. However, one of the subcommittees of our health manpower task force is looking at that issue explicitly, because previously we talked mainly about financing. We are in favor of accepting FMGs for training who then want to go back to their countries. I also believe that we should get away from using FMGs as the health care providers for indigent patients and in inner-city hospitals. We need to make that setting more attractive, both to patients and to graduates of American medical schools, without depriving indigent populations of health care. Perhaps as we turn out more physicians, they will accept salaried positions in sites that are currently devoid of physicians. In this connection, I am glad that Congress has passed legislation reviving the National Health Service Corps, because the corps could step into many of these situations with a cadre of young physicians working off their debt. There is a rural health program on the books that does that as well. I think that it is a good program and should be expanded to other underserved areas.

Priorities Of The AAMC

Q: Under your predecessor, the AAMC appeared to many people in the outside world—Congress and the federal government, for instance—as an organization centered on its advocacy of biomedical research. Of lesser importance seemed to be the interests of medical schools and teaching hospitals, recognizing that it is impossible to completely distinguish among these overlapping interests. Where do your priorities reside as the AAMC positions itself for the future?
A: I do not want to downgrade our efforts in behalf of biomedical research. We will continue them. However, we will spend more time in helping our constituency with clinical teaching and with monitoring the quality of health care—in collaboration with other individuals or organizations. However, we should not take the place of the Joint Commission [on Accreditation of Healthcare Organizations]. We will spend a good deal of time and effort on increasing the number and improving the lot of minorities in medicine. Data that have the minority population increasing, while the entry of minorities into the medical profession is flat, are incontrovertible. We need to address this issue.

Q: Will you turn there, Bob, to the foundation world for support, or to government, or to both?
A: We will turn to both. I am hoping that there will be a different emphasis by government in future administrations. I look at the minority issue as a long-term project. To make any impact, we are going to have to affect educational values and modify educational backgrounds of kids
that are just entering high school. It may be that we will not see improve-
ment in minority representation in medicine until the year 2000, but if we
can do that, I will be satisfied, even though I will no longer be here to see
it. I also would like to see us foster curriculum reform. In a sense, that is
what Ebert and Ginzberg are saying—not much has happened since the
Flexner report and, to date, the Graduate Professional Education of the
Physician (GPEP) report has not had a major effect. A number of schools
are making major educational reforms, but from what I can gather, they
are in the minority. Of course, whatever curricular reforms take place will
be affected by the external environment—the Scylla and Charybdis of
cost containment and competition. I hope that the medical schools will be
more responsive to changes in our society; to the extent that we can
courage that, I am for it.

Q: You have been president of the AAMC now for more than a year. What has
surprised you most about the job? What are the chief levers you can pull to
demonstrate your leadership? For example, is there anything more compelling
than the power of persuasion that you exercise so effectively in your writing?

A: The AAMC is a consensus organization, not one in which the
president can hand down decrees from on high. It is not an organization
that can exert sanctions. We do accredit medical schools jointly with the
American Medical Association (AMA), but that process is carried out at
arm’s length and has nothing to do with our policy positions. I have been
heartened by the support I have received from our constituency and our
leadership. The issue of house officers and their hours and supervision is
a case in point. A segment of our constituency would rather have us do
nothing, and some would like us to have done more and would have us be
more prescriptive than we will end up being. But I do think that we will
come up with an influential paper that will be followed by suggestions for
implementation. Perhaps what we have promoted here is an interdisci-
plinary exchange, because, for the most part, the specialties are looking at
these reforms only in terms of their own specialty. What we want to do is
to promote policies that make the life of the house officer more intellec-
tually rewarding, less physically exhausting, and more pleasant. The only
way we can do this is by the power of persuasion.

Being president of this organization requires getting out in front of the
constituency, but not so far that they lose sight of where the leadership is
going. Moreover, the academic community is slow to change. One thing
that I hope to accomplish, however, is to have the various segments of the
academic community talk more with one another. I include the deans,
the faculties and administrations of our teaching hospitals, and our
students. To the extent that we can facilitate such communication, I will
look at my tenure here as being successful.