The superb essay by Robert Ebert and Eli Ginzberg should be on the “must reading” list for all serious students of the contemporary medical scene. It is difficult to disagree in any way with the premise of the authors, that dramatic changes in American society demand equally profound changes in medical education if future physicians are to function in the real world. It also is difficult to argue with the substance of the recommendations, including a “core” educational faculty, shortening clinical training, decreasing the numbers of foreign medical graduates (FMGs) trained in U.S. residency programs, increasing numbers of physician investigators and minority trainees, “rolling medical school admission” to reflect the differing rates at which students reach career decisions, tying class size to needs and resources, and studies concerning both the financing of graduate medical education and the feasibility of shifting the locus of medical education to ambulatory settings. We must confess, however, to some disappointment in the cautiousness of certain recommendations, given the dramatic alterations in the world of medicine that the authors have described.

Quality applicants. The authors described a decline in the number of quality applicants to medical school without any suggestion of what should be done about this challenge. It is clear that a decreasing percentage of the best students, whether they come from science, math, biology, the humanities, or a combination, are not choosing medicine as a career. Clearly, to reverse this trend, we must deal with the issues of student debt; the costs of medical education; the uncertain future of the profession; the autonomy of physicians; expected income levels; the choice of specialties; the choice of practice locations; the liability crisis; control of the profession by forces external to medicine, where dollars are the primary motivation and not patient welfare; and the decline in the number of twenty-to-twenty-five-year-old Americans.

Continuing medical education. The authors appear to be concerned
primarily with reforming undergraduate medical education and training primary care residents. However, if we are going to have the kind of impact on medical education required to meet the challenge of societal change, reform must occur in the entire continuum, including not only undergraduate but also graduate medical education and continuing medical education.

The majority of time available for education is not in the schools of medicine or residency training, but in the professional life of the trained physician. In this postresidency phase of approximately thirty to fifty years, educators must update the knowledge, skills, and attitudes of physicians as well as provide support while physicians are struggling to adjust to change. This is not to denigrate the importance of undergraduate or graduate medical education, or the impact of these segments on the future of medicine. However, the lag time between a change in this period of education and its impact in the practicing world is very long, especially when compared to the rate of change in society. Therefore, it appears that we must deal with the entire continuum of medical education if we are to have an immediate impact with reforms.

**Core faculty.** The authors recommend that a “core faculty” be established to have complete responsibility for medical education activity. This is an excellent recommendation, and it mirrors the experience gained at a variety of universities, including the University of Washington’s integrated medical curriculum and Harvard’s Oliver Wendell Holmes pathway. It is, however, doomed to failure unless more than funding is provided to support this intrepid band of educational pilgrims.

Will and Ariel Durant, in their classic book *Lessons of History*, claim that no human endeavor has ever been successful unless a “profit motive” of some sort is operative, be it money, prestige, space, or titles. Core faculty, therefore, must have authority over more than salary lines and the medical curriculum. This authority must extend to the appointment and promotion process, space, trainees, operating dollars, support staff, and prestige in the eyes of peers. This involves a much more difficult and complex change than simply establishing a core faculty. One could suggest that medical education be divorced from medical schools and academic health centers because the environment in such institutions is a threat to the welfare of the educational experience.

**Training length and locus.** The authors suggest a shortened period of training combining the last two years of the undergraduate experience and the first three years of the residency training into a total of four years. However, why not place responsibility for all clinical training, regardless of its length, into the hands of the core faculty? Why should subdisciplines of surgery, for example, be exempt if fusion between the two
portions of the educational continuum is desirable? Almost everyone would agree that the fourth year of undergraduate medical education is wasted, and many would support August G. Swanson’s view that the medical degree should be given at the end of “formal training” and not in the middle, as now exists. Hence, why not go all the way and include the training of all residents under the authority of the core faculty? Also, why single out primary care training to shorten by as much as two years? There is slack in all residency programs that can be saved. It might even be argued that primary care trainees need longer periods of training than other specialties, since primary care covers a much broader range of subjects than the more narrowly focused disciplines cover.

**Foreign medical graduates.** Given the large and increasing number of physicians in this country, there is growing sentiment that it is not necessary to have a second stream of physicians in the form of foreign medical graduates (FMGs). Also, many would espouse the view that the United States has no moral obligation to provide practice opportunities for all physicians of the world, and that any reasonably qualified U.S. citizen can now be admitted to U.S. medical schools, given the decreasing applicant pool. Hence, it would follow that there is limited if any need for U.S. citizens to be trained abroad, and there is no longer a need for the continued admission of FMGs to residency programs.

There is also increasing sentiment that the evaluation of the “products” of foreign medical schools by the Educational Commission on Foreign Medical Graduates (ECFMG) process of certification is an inadequate assessment of the competency necessary to enter US. training programs. This follows because an evaluation of the product fails to evaluate the educational experience that the individual has received, nor does it assess the attitudes, values, behaviors, and clinical skills of the FMG. Hence, what is needed is not only an assessment of the outcomes (graduates) of the medical education process, but also an evaluation of the process itself. This is done in the United States through accreditation of medical schools.

The authors’ recommendation that the number of residency positions be decreased to approximate the number of U.S. graduates may close the door to some FMGs. This is politically unlikely to happen. Any group that is powerful enough to gain the attention of federal policymakers and federal agencies including the Federal Trade Commission, which is concerned about possible anticompetitive practices, will resist such an attempt with great vigor. Efforts must be made to increase quality control of foreign medical graduate education to a level equal to that of U.S. medical schools. This includes a formal assessment of the foreign schools if their graduates are to continue to have access to U.S. training programs.
Minorities. I applaud the recommendation concerning efforts to assure that sizable numbers of minorities are included in medical education training and in the profession. Special efforts, however, will be required to achieve this goal, because the factors that impact negatively on the view of medicine by majority groups are magnified in the eyes of minorities. Hence, the task will be very difficult.

In the sense of being underrepresented, there is another group also at great peril: young people from lower socioeconomic backgrounds. For these people, the high costs of medical education, the large debts of graduating medical students, the uncertain returns on the investment, and the often less than adequate academic preparation combine to discourage them about medicine. Medicine simply cannot be allowed to become a wealthy, white person’s profession.

Finances. The authors suggest a study of financing ambulatory-based teaching, especially in graduate medical education. This is a reasonable suggestion and should be implemented as soon as possible. However, this is only one area in the continuum of medical education where finances are critical. The decreased availability of student loans and scholarships, the increased tuition costs, the growing debts of medical students, and the proposal that residents pay tuition, without a corresponding offset for the contributions to patient care and the education of students, all cry out for attention. Therefore, the recommendation should be broadened to include financing medical education in its entirety. Given the economic realities of the country in which one segment of the economy is competing with another for resources, it would not be maximally productive to study funding in only one area and ignore other issues of equal importance.

Clearly, the essay by Ebert and Ginzberg is a major contribution to the medical educational literature, the aforementioned suggestions notwithstanding. It should be read, debated, and implemented. To a large extent, as medical education goes, so goes the profession and patient care in this country. One cannot, therefore, overemphasize the importance of having the right medical experience in place. If nothing else, this excellent work bears witness to the validity of this philosophy. We owe these gentlemen a debt of gratitude for their insight, sage advice, and challenging recommendations, as well as for reminding us of the importance of elevating medical education in the priorities of our professional existence.