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Academic Medicine's Season of Accountability and Social Responsibility

Abstract—The author declares that academic medicine has entered a new and stormy "season" of accountability and social responsibility, due to public concerns about the overall health care system. He reviews earlier seasons, identifying paramount issues or activities that dominated the specific eras the Association of American Medical Colleges (AAMC) has responded to since the twentieth century began. He recommends how the AAMC can achieve several near-term solutions to pressing demands of the current season, such as the needs to manage academic medical centers more efficiently and to restore public confidence in the integrity of biomedical research. Next, he focuses on proposals for academic medicine to provide leadership, through the AAMC, in two major areas: preparing more generalist physicians, and assuring greater access to health care for those who live in underserved urban and rural areas. He describes models of existing, successful programs. The author concludes by proposing to create a "National System of Regional Medical Care." He urges the AAMC to continue its leadership by designating a task force to examine how such a regional system could be established within this decade. *Acad. Med.* 67(1992):68–73.

"Whoever wishes to investigate medicine properly," Hippocrates counseled physicians 23 centuries ago, "should proceed thus: in the first place to consider the seasons of the year, and what effects each of them produces. . . ."[1]

His sage advice remains timely today. A new season engulfs America's health care system, posing severe challenges, especially for academic medicine. Consider this sampling of recent headlines:

Newsweek: "The Revolution in Medicine"
Fortune: "Taking on Public Enemy No. 1"
The New York Times: "Ringing: The Health Care Alarm"
The Wall Street Journal: "Medicine Appears Costly, Researchers Say"
Business & Health: "Physician, Cut Thy Costs"
Nation's Business: "Curbing Costs of Health"
The New York Times: "Demands to Fix U.S. Health Care Reach a Crescendo"
The Houston Post: "Church Leaders Decry Nation's Medical Care"
U.S. News & World Report: "Doctor's Dilemma: Treat or Let Die?"
Business Week: "Driving Down the Costs of an Aging America"
U.S. News & World Report: "Alzheimer's"
American Medical News: "Medicine for a New Generation"
Newsweek: "Milking the Laboratories for Dollars—The Overhead Mess"
Newsweek: "The Antibodies that Weren't: Federal Investigators Find Fakery in Biology Lab"
Time: "Scandal in the Laboratories"
Newsweek: "The Big Business of Medicine"
The New York Times: "Medical Technology Arms Race Adds Billions to the Nation's Bills"
The Washington Post: "Medical Care: How Much Health Care Can We Afford?"
Newsweek: "State of Emergency"
Newsweek: "Not Enough for All—Oregon Experiments with Rationing"
The New York Times: "Why Emergency Rooms are on the Critical List"
Corpus Christi Caller: "Doctors in Short Supply—Rural, Poor Areas Rely on State Incentives"
American Medical News: "Healing the Homeless"
Newsweek: "Can You Afford to Get Sick?"
Business & Health: "Health Care Reform Comes to Washington"

Obviously, as these shouting headlines illustrate, this new season is a stormy one. It has propelled medicine to the center of public attention in the United States and throughout the world. Already we have entered the political season that will culminate in the nationwide elections of November 1992. Health care reform, as *The New York Times* declared editorially on November 8, 1991, looms as "Topic A on the domestic agenda." Front pages will continue to headline such issues as the high costs and inadequate coordination of medical care, health needs of women, the AIDS epidemic, and even the ethical issues created by technological advances.

Ironically, it is the impressive progress achieved by academic medical centers that is prompting the public to ask—and public officials to demand—that the medical profession accept responsibility for failures of our nation's health care system. Americans ask why medical costs continue to rise while millions of people are denied access to quality care provided by teaching hospitals—or to any care at all.

We cannot dispute the public's prerogative to examine our performance. Public funds—through governmental appropriation, tax-exempt philanthropy, or tax-deductible business investment—finance our academic medical centers. As we have diligently advanced medical knowledge and patient care, we have paradoxically created political and economic problems of ominous proportions. These issues trouble the public, and they threaten the integrity of medicine as we know it.

How we respond to the challenges that these problems and issues pose will, in a broadening sociopolitical environment, inevitably determine the

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fate of our profession and its institutions in the twenty-first century.

The Association of American Medical Colleges (AAMC) has a 115-year tradition of responding ably to changing public demands. That is a valuable legacy. Drawing upon it, in this new season, we need to set priorities, exert leadership, and initiate actions to meet public needs of the 1990s and beyond.

Previous Seasons

The speeches of past chairs of the AAMC help to define the changing seasons the AAMC has faced. The season of paramount concern in the first 30 years of this century, as expressed in these talks, centered on elevating standards of medical school admission, curricula, and instruction and of medical care. Those topics received major emphasis in 24 chairmen's addresses between 1900 and 1930. We might aptly call the early part of this century the "season of standards" in medical education.

In the second 30 years of the century, from 1930 to 1960, admission and curricula were still key issues in the addresses of AAMC chairmen. But leaders of the 1950s stressed how society should support the expansion of medical education and research. Thus, the "season of faculty development" flourished.

Beginning 30 years ago, in the 1960s, modern academic medical centers began to evolve and were embraced by their communities. Our nation endorsed the concept of federal support for health care through the Medicare and Medicaid programs. Federal funding for research expanded rapidly with the growth of the National Institutes of Health. The 1960s clearly were the years when the "season of academic medical centers" began.

But by the 1970s, we entered a "season of governmental control and influence," a subject mentioned in the presentations of 14 of the last 20 AAMC chairs. The 1960s and 1970s also brought major changes for the AAMC, as it expanded to include representation of teaching hospitals, faculty, and students, as well as deans.

By the mid-1980s, as pointed out by Richard Janeway in his 1985 address, society's expectations and academic medicine's performance were influenced more by issues of cost, competition, and profit than by the "Great Society" issues of quality, access, and compassion that had dominated the 1960s.[2]

The Present Season

Now we have entered a season dominated by societal concerns about the overall health care system. This is the "season of accountability and social responsibility." Accountable is defined as being "answerable" and "explainable." We should champion both vigorously.

Social responsibility has always been a fundamental tenet of the medical profession, ranking among the top ten topics of emphasis in AAMC addresses in each 30-year period of this century. Most recently it was championed by John Colloton in his 1988 address, "Academic Medicine's Changing Covenant with Society."[3] This theme also has been expressed cogently by persons outside the AAMC, for example, by Stephen Schroeder and his associates, in their 1989 article, "Academic Medicine as a Public Trust," and by David Rogers, Arnold Relman, and many others.[4-6]

Thus, while academic medicine has long recognized its responsibility to society, never before has this responsibility been coupled so dramatically with the public's demand for accountability.

I propose that the AAMC immediately marshal leadership from within academic medicine toward providing near-term remedies to pressing concerns. Without delay, we should initiate actions to

- manage our institutions more efficiently;
- restore public confidence in the integrity of biomedical research;
- increase representation of ethnic minorities in medicine;
- expand health services research;
- define ways to provide medical care more cost-effectively;
- reshape medical education to meet our rapidly aging population;
- thwart the tendency toward commercialization that taints almost all our activities;
- develop strong research and educational programs in environmental and occupational health; and
- become a recognized force in addressing global health issues, including pollution and population control.

Few question the urgency of forthrightly addressing these matters. But often we in academic medicine have not acknowledged that our obligations extend beyond the boundaries of our medical centers—to regional, national, and world health issues.

All of us realize that proposed reforms of our nation's health care system are now so numerous that they are paralyzing each other. Academic medicine has generally avoided this debate, yet we train the majority of physicians and other health professionals. We create new medical treatments and technologies, and we operate the most sophisticated medical facilities that are hubs of the entire medical system. Logically, we can no longer be passive. In this new season, we must actively help to reshape our nation's health care enterprise.

Two Issues Demanding Leadership

I would like to focus on two issues of national concern where I believe academic medicine can—and must—exert strong leadership in working with others to correct deficiencies in our nation's system of health care.

Specifically, (1) How should we respond to meet a perceived shortage of generalist physicians? (2) How can we assure access to medical care in underserved rural and urban areas?

Regarding the first question, criticism is growing about academic medicine's inability to produce more generalist physicians. Despite recent downward trends, the 1990 AAMC Task Force on Physician Supply concluded that more, not fewer, primary

care physicians probably will be required in the future, and that medical education should respond to this likelihood.[7] Distinguished academicians have strongly supported this position. They include Paul Beeson, Robert Ebert, Sherman Mellinkoff, Robert Petersdorf, David Rogers, and many others.[8-12]

The second question is also about an issue of national concern that has produced criticism of academic medicine: that we have failed to meet the health needs of inner cities and rural areas.

Academic medicine cannot solve these problems immediately.

To remedy these situations, there is a need both to increase the supply of generalist-physicians and to restructure the health system itself. Incentives are essential to encourage new graduates to enter practices that fulfill society's needs. It is also imperative that the system provide more support to them in their practices. If we address only the supply side without providing ways to make the practice of medicine more attractive in these settings, we will almost certainly fail.

Preparing Generalist Physicians

First, let us consider the generalist-physician issue.

Fewer students are seeking careers as generalists. Looking back nearly 30 years, we find that half of all physicians were in office-based primary care, compared with one-third today, although the number of office-based primary care physicians per 100,000 population actually has decreased only slightly. At the same time, there has been an increase of nearly 89% in non-primary care office-based physicians.[13] The 1989 AAMC Graduation Questionnaire clearly reflects the diminishing interest since 1981 of graduating medical students in family practice, general internal medicine, and general pediatrics.[14] The decline of interest in general internal medicine is more than 50%. These changes also are demonstrated by the continuing difficulty of filling residency positions in primary care. Positions filled in family medicine dropped from 95% in 1984 to 84.3% in 1990[15-17] along with a decrease in the percentage that the four primary care residencies make among all filled residency positions, from 50.4% in 1980 to 43.2% in 1990.[17-18]

Two major factors that influence career choice in medicine are (1) preexisting preferences and social ideologies; and (2) learning experiences during medical school.[19-21]

Therefore, the admission office is the first gateway of opportunity, a point emphasized by Kay Clawson in his 1989 chairman's address.[22] We will only perpetuate the trend toward specialization, which began in the 1950s and 1960s, if medical schools continue to admit students narrowly trained in biological sciences at the expense of broader education. However, we can enroll more science-oriented students who desire to be generalists. We can attract students who express a strong interest in practicing in underserved areas. If we foster these students' social ideology while they are in medical school—for instance by involvement with ambulatory and general care experiences that are educationally meaningful—we can have an impact.[19]

Current programs offer helpful guidance. In the University of Washington's regional medical educational program in Washington, Alaska, Montana, and Idaho—the WAMI program—61% of the students who were exposed extensively to primary care in the program ultimately chose primary care disciplines.[23] Only 27% of the students without WAMI experience chose primary care. Minnesota's Rural Physicians Associate Program provides nine months of community-based training for selected third-year medical students.[24] Seventy-four percent of the participants have chosen primary care as careers.

To encourage broader interests and lessen the intensity of the "premed" syndrome, we can encourage students to confront broader issues facing contemporary society.

Baylor College of Medicine is one of several schools experimenting along these lines. In 1990, we began a program with neighboring Rice University whereby high school seniors are selected jointly. They are offered reserved positions in our medical school after graduation from Rice. These students, who will constitute 10% of Baylor's entering classes, are required to take the full four years of undergraduate curriculum. They are counseled throughout to achieve a broad range of educational experiences, particularly in humanities and social sciences. We believe these students will develop a stronger understanding of the human environment and a deeper social consciousness that will endure in their future medical careers.

Within our medical schools, we also need to promote more training in social and behavioral sciences and place greater emphasis on primary care research.[25,26] Mentors can nourish students' interests in general care. We should therefore establish faculty structures that assure prestige and stature for general medical disciplines.

We should give students a better understanding of the complexities of the entire health system. We must teach students about their future roles as educators of patients, a concept emphasized by Daniel Tosteson in his 1974 chairman's address.[27] We can link medical schools with community clinics.[25] Several primary care advocates suggest mandatory time in community service for all medical students or graduates—a suggestion that merits serious consideration.[5,28]

A third factor in career selection that cannot be overlooked is financial. The average income of pediatricians and family physicians is only 68% of the average income of all U.S. physicians.[13] Obviously, the level of income deters some students from careers in general practice. Federal legislation has been proposed to provide more equitable financial reimbursement for general care physicians. We should work for such incentives.

We should find ways to waive tuition when students select special primary care tracks in medical school. We can seek government support to

pay much higher stipends to residents in general care programs—say $50,000 per year—to encourage residents to maintain commitments to be generalists. These incentives would discourage young physicians from gravitating, solely for financial reasons, toward specialty training.

Undoubtedly, the need for highly skilled specialists will increase in the years ahead, but, as surgeon William Anlyan told us in his 1971 address, we also must provide a better balance of specialists and generalists.[29] The generalist, after all, is the cornerstone of the medical profession.

Health Care in Underserved Areas

We must be aware, however, that merely graduating more general care physicians may not directly address the immediate needs of the medically underserved in America's rural and urban areas. Family and general practitioners provide over 90% of the medical care in counties with populations of less than 10,000.[30] Yet an 8.1% decrease in primary care physicians per 100,000 population in nonmetropolitan areas occurred between 1963 and 1986,[13] and the number of new physicians interested in practicing in communities of fewer than 50,000 declined by almost 50% from 1981 to 1989.[31] If merely producing more general care physicians in the near term will not solve the medical needs of rural communities, what can academic medicine do? Again, we can learn from existing medical school initiatives.

In Jefferson Medical College's Physician Shortage Area Program, for example, approximately 24 students admitted each year from nonurban areas pledge to enter family medicine and to practice in underserved areas.[32] In the University of Washington program, almost twice as many students from the WAMI program choose to practice in nonmetropolitan areas as do those without WAMI experience.[23] In the Minnesota Program, 59% of the graduates who have remained in the state practice in rural communities.[24] The premise underlying these programs is that new physicians cannot be expected to locate in rural communities unless they are exposed to them.

Academic medical centers should also seek ways to encourage physicians who aspire to practice in medically underserved areas. We can, for example, work for student loan forgiveness and for government support of graduates' clinic start-up costs, continuing education, and consultation with colleagues in academic centers.

Not all schools can bring about uniform changes. However, whether slight changes are made in all schools or substantial changes in a few, strong institutional leadership will be essential.

The AAMC already is exerting leadership to bring the primary care issue into perspective. Two focus sessions on primary care were sponsored by the AAMC in the fall of 1991. Their input will provide guidance in the development of an AAMC Action Plan to facilitate change.

Organizing a Regional System

As we review selected medical school initiatives we become aware of another and perhaps more troubling problem: the organization of the health care system itself. We must address this fundamental issue.

I propose that academic medicine take the leadership to bring mainstream medicine directly to every underserved area of this country in a "National System of Regional Medical Care." To succeed, a national system must be tailored to regional needs. The diversity of requirements for health care has posed an almost insurmountable obstacle to devising a simple, uniform federal system. The types and magnitudes of required medical services vary greatly from one area of the country to another, and nobody knows local needs better than those who live in the area.

It makes sense, procedurally, first to identify places throughout the country where populations, both urban and rural, are medically underserved and then to delineate a series of regions where planning would be coordinated around the particular medical needs and requirements of each region. The regions would be obliged to comply with general mandates in order to qualify for federal funding. One example might be the inclusion of population-based health services research. But each region would be given broad flexibility to design and implement its own system of medical care.

Academic medical centers and medical schools, by virtue of their expertise, resources, and positions of prestige throughout their domains, should be delegated the leadership—under a federal grant program—to facilitate planning for structures and systems most suited to their regions. This planning responsibility would be undertaken with the full participation of a broad range of persons and institutions, all with the potential of contributing to an integrated health system in their areas.

We should re-examine the concepts underlying the Regional Medical Program proposed in 1964 by the President's Commission on Heart Disease, Cancer and Stroke.[33] That proposal envisioned linking every physician and community hospital to a national network capable of transmitting the newest and best in health service and research. The Regional Medical Program did not fulfill its potential, partly because academic medical centers—critical to any regional solution— had not matured sufficiently to provide the essential leadership and support. Also, 25 years ago, modern telecommunications, indispensable for implementing any regional system, had not been developed.

We can also learn from the successes of the Area Health Education Centers, or AHECs, which have existed in various forms in 37 states and have involved 55 medical schools.[34] These have fostered the education of health professionals in non-urban settings, in some cases for nearly 20 years. In North Carolina, to cite one program, the physician-to-population ratio in rural communities is higher than that for comparable communities nationally, a difference attribut-

able to the state's AHEC programs.[35]

Space constraints preclude mention of many other recent initiatives in regional planning, but one other that I would like to mention is the Health of the Public program, a pilot study funded in several academic medical centers by the Pew Charitable Trusts and the Rockefeller Foundation.[36] Academic medical centers are challenged to assume institutional responsibility for maximizing the health of a defined population and to be involved in decision making about the development and deployment of community health services.[37] Clearly, this approach attempts to integrate individual and public health services, which unfortunately have been separated from each other for the better part of this century.

To establish regional systems integrated within a national plan will entail great effort and commitment from many persons, agencies, governmental entities, and the practicing medical community. It will require shifting some health care resources and funding. It will rest inexorably on the political will of the President and Congress.

A Proposal

Academic medicine must work with others for the enactment of well-conceived legislation. I propose that an AAMC task force be commissioned immediately to examine the feasibility of establishing the "National System of Regional Medical Care" that I have briefly sketched. This task force also should look at existing, innovative programs to enhance rural and urban medical care and recommend the best way for academic medicine to exert leadership to solve these problems. I challenge this task force to devise a model that can be applied nationally and be in place within this decade.

I am convinced that as an obligation of the extraordinary public trust held by academic medicine—a trust described by Robert Petersdorf in his 1978 chairman's remarks[38]—the AAMC can and *must* take this leadership role. We can be the catalyst in building a national health program to include all Americans and reduce per-capita expenditures for medical care. As Virginia Weldon told us in her 1986 address, "The challenge of leadership . . . is the ability to command the public's attention and to engender political will."[39] In providing this leadership, we can demonstrate clearly that we are sincere about equitable health care for all citizens—and that continuing public support for our tertiary care centers is fully justified.

The nation's political climate now favors a workable national health plan. We must be prepared with a realistic proposal and willing leadership to utilize medical resources in each region of the country most effectively to achieve this national priority. The alternative is to invite a government-mandated program that probably will not be sensitive to local community needs or to the most efficient use of medical resources.

Let us affirm—in this new "season of accountability and social responsibility"—a vigorous commitment to leadership that will ensure the public's steadfast trust of academic medicine in the seasons of the twenty-first century. As Hippocrates observed, "For extreme diseases, extreme methods of cure . . . are most suitable."[40]

Upon us is the season to prescribe an extreme cure.

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ROBERT G. PETERSDORF, M.D.

Not a Choice, an Obligation

Abstract—The author traces the gradual increase of educational opportunities for underrepresented minorities that began in the mid-1950s and indicates the role played by the Association of American Medical Colleges (AAMC) and individual medical schools in the 1960s and 1970s to increase minority enrollment in medical schools. Minority enrollment did grow dramatically for awhile, but since 1974 the nationwide percentage of minority students enrolling has remained about the same despite the rising percentage of minorities in the population (although some individual schools have recruited and graduated relatively large numbers of minority students). The author then emphasizes how crucial to the nation's future it is to reverse this trend and achieve equity of opportunity for minorities by enhancing their educational opportunities. He maintains that academic medical centers must become involved in identifying and assisting capable minority students well before they are potential applicants to medical school, thereby helping to enlarge the pool of academically qualified minority applicants rather than relying on more aggressive recruitment from the existing small applicant pool. Enlarging the minority applicant pool is the cornerstone of a new AAMC campaign nearly to double the number of underrepresented minority matriculants by the beginning of the next decade: *Project 3000 by 2000.* The short-term and long-term strategies of this campaign are described; it focuses on creating partnerships with high schools and undergraduate colleges and will be based in part on a variety of existing and successful efforts of this type being made by individual medical schools, private foundations, and the federal government. The author closes by asserting that to better educational opportunities for minorities is not a choice; it is an obligation. *Acad. Med.* 67(1992):73–79.

I invite you to indulge with me in a bit of reminiscing back to the 1950s, when I and perhaps many of you reading this article laid the foundations of our professional careers. In the postwar boom economy, our future possibilities seemed endless, limited only by our ambitions and talents. It is no wonder that I remember the 1950s as the "good old days." Obtaining what you wanted—whether it was a house or a college education—seemed to be within reach if you worked hard and played it smart—especially if you were white.

It is no secret that the 1950s were not such a favorable time for minority citizens. Oppressive laws and a long and continuous tradition of racial prejudice restricted educational opportunities for minorities. This began to change very slowly with the watershed Supreme Court decision of Brown v. Board of Education in 1954. In that era, the medical profession was not significantly different from the rest of society in the restrictions it placed on minorities.

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