

# Virtual Mentor

American Medical Association Journal of Ethics  
November 2009, Volume 11, Number 11: 896-899.

## MEDICINE AND SOCIETY

### Medical Education Meets Health Care Reform

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Finally, health care reform is back on our national agenda. As of this writing, however, one wonders if anything useful will emerge from what has turned out to be a viciously partisan debate among our elected officials. Amidst all the rhetoric about public options, tax increases, death panels, and rising deficits, there has been little if any discussion about the role that medical education will have to play if we are ever to get true reform of our seriously malfunctioning system.

In this brief article, I highlight four critical aspects of reform that medical educators must find ways to address—the adequacy of the physician supply, the composition of the physician workforce, the geographic distribution of physicians, and last, but far from least, the competencies required of doctors in a meaningfully reformed system.

*Adequacy of the physician supply.* It goes without saying that a key goal of health care reform—extending health care insurance to those who are presently uninsured or underinsured—will fail to improve the nation’s health if doctors are not there to provide the needed care. Which is not to say that doctors could or should do all the work that will be required. Clearly, many other health care professionals will be needed, and are needed now, to ensure access to necessary services. But few would disagree that the number of physicians presently available is inadequate to the task. Indeed, even without the increased demand stemming from universal health insurance, more doctors will be needed in the future simply to care for our growing and aging population.

In recognition of the looming physician shortage, the Association of American Medical Colleges in 2006 called for a 30 percent increase in the capacity of the nation’s medical schools over the subsequent decade. Medical educators have responded vigorously; several new schools have been launched, more are in the pipeline, and most existing schools have expanded their class sizes. But producing an adequate number of physicians, while obviously necessary, is hardly sufficient to meet medical education’s obligations to support health care reform. Also required is an appropriate distribution of new physicians across the various specialties and geographic regions of the country.

*Composition of the physician workforce.* One especially problematic feature of the current composition of the workforce is the relative paucity of primary care physicians on the front lines of delivery. Virtually all analysts agree that reform can meet its goals of high-quality, affordable health care for everyone only if the system

rests on an adequate foundation of primary care services. Hence, unless the specialty distribution of the future physician workforce is shifted dramatically from its current skew toward more narrowly defined fields, other sectors of the workforce (e.g., nurse practitioners) will be required to fill the need.

Since the retreat from the managed-care era of the late 1990s, the specialty choices of graduating medical students have veered significantly away from the primary care disciplines of family medicine, general internal medicine, and general pediatrics. The reasons that students abjure primary care are many, and some of the most influential (e.g., lifestyle, income disparity) are clearly beyond the reach of medical education. But medical schools *can* influence several factors that, in aggregate, could help restore a more appropriate balance among the specialties. They can, for example, give careful attention to career aspirations in deciding whom to admit; provide early, positive clinical experiences in primary care settings; ensure the active participation of primary care role models in the educational program; counter the all-too-frequent disparagement of primary care by respected specialists on the faculty; and advocate for improvements in the compensation and working conditions of primary care physicians in the community.

A second especially problematic feature of the current composition of the workforce is the marked skew in the racial and ethnic backgrounds of physicians. Whereas gender parity has been achieved in medical school admissions over the past several years, the gap in admissions continues to grow between the increasingly diverse makeup of the U.S. population and continued underrepresentation of African Americans, Hispanic Americans, Native Americans, and other minority group members. Medical educators must persevere in their efforts both to increase the number of students from minority groups who aspire to become physicians and to achieve racial and ethnic diversity among those admitted. Once again, system reform can fulfill its promise to provide high-quality, affordable care to all Americans only if all physicians are educated in a diverse environment that fully prepares them to deliver culturally appropriate, equitable services.

*Geographic distribution of physicians.* Achieving an appropriate geographic distribution of physicians has proven to be a particularly nettlesome problem virtually everywhere in the world. Even in the United States, where the overall doctor-to-population ratio is one of the highest in the world, many rural and inner-city communities are woefully short of physicians. The reasons that doctors tend to aggregate in more affluent urban and suburban areas are perfectly clear; that is where they have abundant professional colleagues, more career opportunities for spouses, less-restricted educational options for children, easy access to cultural events, and, of course, better prospects for higher incomes.

Achieving all the objectives of health care reform will be a hollow victory for those who currently live in medically underserved regions of the country if they remain isolated from adequate medical care. Admittedly, medical educators cannot solve the problem of physician maldistribution by specifying where their graduates will

ultimately practice. They can, however, make a concerted effort to recruit and retain medical students who hail from medically underserved communities and who are, as a consequence, more likely than others to return to such communities upon completion of their training.

*Physician competencies.* Successful health care reform will require that physicians acquire and demonstrate certain competencies beyond the diagnostic and therapeutic skills traditionally thought of in connection with “competent” doctors: (1) patient-centered care, (2) participation and leadership in teams, (3) dedication to quality improvement and patient safety, (4) systems-oriented care, (5) accountability and performance measures, (6) commitment to prevention and health promotion, (7) focus on population and public health, (8) delivery of cost-conscious care, (9) self-directed learning; informatics, and (10) professionalism.

The teaching of several of these nontraditional competencies has heretofore not been high on the agenda of medical education. But to prepare future doctors to fulfill the expectations of a high-performing health care delivery system, medical educators must ensure that newly minted doctors understand the importance of patient-centered care and that they can function effectively as leaders and participants in multidisciplinary teams of health professionals.

To play their essential role in reducing medical errors and improving the overall quality of patient care, future physicians also must acquire intimate knowledge of how complex systems function and must be willing and eager to have their performance in practice measured and held to account. To achieve many of the system reform goals, physicians will be called upon to implement new strategies for health promotion and disease prevention and to incorporate a public health perspective with its emphasis on the health of populations. All of these objectives must be accomplished within a resource-constrained system, requiring educators to inculcate in their students a keen understanding of how to practice medicine with extreme cost-consciousness.

Health care reform efforts have recognized the enormous potential that information technologies have for improving health outcomes and for increasing efficiency. Hence, competency in managing information electronically is yet another skill doctors will need to acquire to function optimally in a reformed system. Increasingly, they will be expected to use IT-enabled means for retrieving information for self-directed learning, ensuring accurate decision making in real time, and fully documenting patient encounters.

Arguably the competency most urgently needed to ensure successful health care reform is an unshakeable commitment to the principles and responsibilities of professionalism. No matter what shape reform takes, no matter how physicians are to be compensated in the future, no matter what structures are created to deliver services, doctors must remain steadfastly adherent to the core principle of professionalism—the primacy of patient welfare. The complexities of human

disease, risks associated with various treatment options, and temptations physicians have to yield to self-interest are all ineluctable features of medicine and, hence, will survive any conceivable transformation of the system. Consequently, for any reformed system to deliver on its promise of high-quality, affordable health care for everyone, future physicians must be strongly grounded in the ethical principles of professionalism and must remain unswervingly dedicated to their patients' best interest.

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