♦ *Executive Director and Secretary, American Board of Family Practice*

Introductory Remarks

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THE AMERICAN BOARD OF FAMILY PRACTICE BEGAN MANY YEARS BEFORE its official approval as the 20th primary medical specialty in 1969. The concept of a generalist specialty lurked in the minds of many; the actual creation of the Board itself was the product of a few but dedicated general practitioners who saw the inherent need for a generalist specialty and gave support, time, and energy toward its creation. We will forever be grateful to those committed physicians.

In observance of the 20th anniversary of the approval of the American Board of Family Practice as the nation's 20th primary specialty, we, at the Board, decided to have a celebration in the form of a medical symposium. It has long been a dream of mine to gather a few of the nation's great medical leaders, put them in a room together, and ask them to speak their minds about medical education. In order to do this, it was obvious that we had to choose "free thinkers" or those who were noted not only for their general leadership and prestige in American medicine, but also for having no qualms about stating their beliefs. What follows is a result of this selection—a symposium entitled, "Medical Education: Time for Change."

Having lived through some remarkable changes in medicine, both as a practitioner and educator, I, for one, have become somewhat disgruntled about many things that I have witnessed in both the world of practice and academe, and, of course, in that Acherontic domain of medical politics.

There was a day when the physician was held in very high esteem and revered as a special member of society. I happen to have been in practice during the last few years of that era. Then, as technology burgeoned and society changed its values, so did medicine's image change in the public eye.

Hearken back to the days when medical schools had more of the disciplinarian-type of teacher, when physicians were more paternalistic (indeed!); when many students answered, "Sir!" to their professors; when professors were highly dedicated and lived on meager salaries; when the patient-physician relationship was sacred, honored, mutually respectful, and meant a truly personalized care and caring; when a student who deserved to fail was failed and not approached with the apologetic phrase, "What have *we* done wrong?"; those days when elitism was a phenomenon evolved of *earned* respect and mutual concern between physicians and patients.

Today, medical schools—for a large part—contain more of the apologist/teacher, many of whose salaries are as much or more than their

practitioner colleagues earn, but who are no longer willing to sacrifice the income differential for the privilege and distinction of being called "Professor." Today, being paternalistic is discreditable. True, a few "paternalistic" physicians of yesteryear abused this relationship with patients, but most of us who were in practice during the end of that "golden age" of medicine accepted with this role of authoritarianism the accompanying "anagke" (αναγκε)—the *need* to accept that *awesome responsibility* for the patient—which meant getting up all hours of the night to see a sick patient or to call a patient's home in the middle of the night when the physician was duly concerned about the patient's condition: it went with the territory, as it were. Just as *oblige* goes with *noblesse;* no egalitarianism here!

Lest one think that all mid-century medicine was "golden," one must toss into the equation that in the practice of medicine of 50 or 60 years ago, with its wondrous humanistic image (the country doctor sitting at the patient's bedside by the lantern light, chin in hand, concerned, but helpless), there were no antibiotics, no blood replacements, no high technology. Cardiac surgery, computers, MRIs, etc., were not in the armamentarium of physicians of yesterday; their paternalistic *caritas* was about all they had, but they *did* have it. In short, for reasons about which one can conjecture for days, "high-tech" rose sharply with all sorts of medical miracles being performed but at the expense of the *caring* quality. Let me hasten to add that I believe that there *still* is a majority of physicians who practice "caring" medicine, but there is the perception that physicians in general care less than they did several decades ago. If so, why aren't these two characteristics (high-tech and caring) synergistic rather than what appears to be in inverse proportion? To put it in the words of my old friend, Bill Ross of Texas, "Why does it seem that the more we learn, the less we care. Does this mean that knowledge breeds contempt?"

Isn't it time for change? If so, as this symposium presumes, what should be done? Shouldn't changes begin in the early education of the physician? Some of us believe that the 4th year of medical school, in particular, is not being efficiently spent. Some specialties complain that medical school graduates are abundantly impregnated with scientific knowledge but remain inadequate in the fundamental but important skills of physical diagnosis, using a stethoscope, and performing a comprehensive history and physical examination. After the demise of the rotating internship, it became apparent that medical schools were not, in general, filling the bill with basic clinical skills, so the transitional year was created to satisfy particularly non-bedded specialties with physicians entering graduate training with at least basic clinical experience. Perhaps it's time for a complete revamping of the entire medical curriculum, regarding it as a 48-month block to incorporate not only understanding of the technological scientific aspects of medicine that we enjoy today, but also to include *rigorous* clinical training—(no exceptions!)—so that a graduate can go into any specialty with clinical essentials.

Perhaps this could be expanded to include the premedical courses together with the 4-year medical school curriculum forming a 7- or 8-year block in which liberal arts courses would be required concurrently with the basic preclinical sciences before the student begins the clinical sciences. Can the medical school curriculum be revised so that every hour is fruitful in producing clinically sound but undifferentiated physicians? Why can't medical educators, as well as clinicians, have more to say about premedical education and what it should include? It makes sense that to have medical school graduates highly qualified to enter specialty training programs (graduate

medical education) and be successful, they must have been properly grounded in the courses in medical school. Carrying this retrospectively, then, for one to be successful in medical school, one must have mastered the basic requirements for medical school courses; hence, we're looking at a 7- or 8-year continuum.

The Roman concept of the liberal arts was to master the *trivium* (grammar, logic, and rhetoric) before entering the *quadrivium* (arithmetic, geometry, astronomy, and music). Together, these "seven liberal arts" or "pillars of wisdom" were the propaedeutic skills that marked only the beginning of the real or vocational study. Hence, the trivium (premed) leads to quadrivium (medical school); together they constitute the propaedeutic skills necessary to enter graduate medical education. Can twenty-first century medical education learn from the ancient Romans? Is it time for change from bottom to top?

All this aside, let's hear what our symposiasts have to say. They generously allowed us to transcribe their remarks; they edited the transcriptions.