Special Article

The future of American medicine[1]

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The author discusses the far-reaching changes that have been taking place in the medical field, the effects that these changes have had on the current practice of medicine, and some of the future changes that can be anticipated. Advances in basic science and in technology have brought about rapid changes in diagnosis and treatment, and changes in social consciousness have both made medical care more available to a larger proportion of the population and also changed the delivery of that care. Changes in the financing of medical education affect the people who enter the profession and their choice of specialties. The emergence of prepaid practice plans, the application of business methods to health care, and open competition in the health care marketplace have already changed health care delivery, and will no doubt continue to do so. Likewise, computer technology continues to change medical practice drastically, and the problem of physician liability is far from being solved. The survival of medicine as a discipline will depend on the ability of its practitioners to adapt to the changing environment, to plan for rational change, and to accept a new social responsibility in addition to their traditional commitment to scientific excellence.

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When I contemplate the names of those who have preceded me on this podium—Crile, Kolff, Sones, Dustan—and those currently on your staff who enjoy international reputation in internal medicine—Gifford, Vidt, Farmer—I am properly intimidated. I suspect that even my old friend and editorial preceptor Irvine Page might have shared my sense of insecurity at being so presumptuous as to tackle the subject of this lecture: "The Future of American Medicine."

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It is a truism that change is coming upon medicine with startling rapidity; indeed, the light at the end of this particular tunnel has turned out to be an express train. And it is bearing down upon us with alarming velocity. Today I would like to explore several major areas: How we got where we are, how future events may influence undergraduate and graduate medical education, and how they will affect the practice of medicine.

I will discuss each in turn, but first—why is all this happening?

I have been called an anachronism, a term I prefer to curmudgeon (which I have also been called). But I still find it difficult to consider myself a "rapid growth industry" that consumes more than 11% of the "gross national product." I still refuse to consider my patients as "consumers" who regard me as a "vendor" or "provider" competing in the "marketplace" of health care! I find these all utterly detestable words. The times are temptestuous for medicine. Our once tranquil world, where we practiced our brand of benign paternalism, caring only for our patients, insulated from events in the mainstream of politics and commerce (a sort of medical Camelot) has disappeared forever.

Today we do not lack strident doomsayers and noisy detractors who deplore our alleged fall from grace as a noble profession. But in the midst of this travail there is one fact that stands as an island of solace. Each of us in medicine reaches back to our antecedents with whom we share a common, timeless, emotional bond: as physicians we cherish and nurture the special covenant we share with our patient, the Aesculapian obligation that no external force will be allowed to intrude upon our duty to bring the best possible care to this patient for whom we have accepted responsibility.

And I will take one further step in my excursion into sentimentality. I feel that the care of patients is still regarded by the vast majority of our colleagues in medicine as a special calling, a privilege granted by society. The practice of medicine represents a rare combination of felicitous factors: an unsurpassed opportunity to help humanity, plus the opportunity to enjoy a life's work that is forever stimulating intellectually yet provides rewarding social status and reasonable financial comfort. I believe that abiding appreciation of this rare good fortune resides deep in the psyche of every good physician and permeates all aspects of life. It sustains us in our darker hours. Trouble arises when we take all of this for granted, when humility gives way to arrogance. But I think this is rare.

Alas, Uwe Reinhardt, the Princeton economist, takes a dim view of this naive and perhaps self-indulgent perception. He contends that our history as a class of professionals, when viewed from the aspect of fulfilling our social responsibility, is not enviable; it does not earn us very high marks. Reinhardt concedes that the physician of today is a skilled, technically competent professional, but he says we have become engaged in competitive commercial enterprise. Fee for service makes us all entrepreneurs, and we are no better and no worse than other professionals; we should not entertain any "holier than thou" illusions.

And if you look at our record over the past 25 years there is some truth to this allegation, disquieting though it may be. Our record of innovating or even of embracing social progress does not gleam with altruistic virtue. Our tradition of clinging to the status quo and our concentration in felicitous geographic areas are facts. I must confess that I can understand Reinhardt's cynicism but certainly not his pessimism. In my opinion we are the unwitting victims (or eager beneficiaries, depending on where you stand) of a remarkable sequence of events. Let me trace it for you.

As physicians, we rode the crest of the revolution in social reform that swept this country in the fifties and sixties. Physicians were disinterested bystanders. We were quietly tending our patients while visionary politicians and legislators made the remarkable decision that race, age, and economic status would not exclude any citizen from adequate medical care. It was a major watershed for American medicine. It was translated into Medicare, Medicaid, and other federally financed medical care programs. Medicine was caught up in this momentous tide, and there were very few among us who failed to share in the bonanza that fell into our laps in the mid-sixties, as an indirect spin-off of this outburst of civilized social behavior. As with so many other splendid, humanistic, public-spirited enterprises, when heart wins out over pocketbook, we are feeling the unforeseen and unanticipated financial consequences. I will address this later. But it was a glorious moment in the history of western civilization.

For physicians this sudden affluence was unprecedented. Before Medicare, the only rich doc-

tors were those who had either inherited wealth or married rich spouses. They were represented by a handful of Harley Street and Park Avenue surgeons who attracted a carriage trade practice. But for the most part physicians were far from wealthy. The horse and buggy doctor was not a myth; most doctors could not afford a car. Medicine was not a lucrative profession until the mid-sixties.

Our current affluence carries a significant price. The BMWs that have replaced the Fords in the hospital parking lot have sent an unmistakable signal to the public. Rightly or wrongly, they resent that many of us have become rich by taking care of sick people. As one of my friends expressed it, "It somehow disturbs my sense of propriety—the physician-priest obligation of service and all that; it just does not seem right." And it has cost us in status, prestige, and trust.

Thus, we enter the mid-eighties engulfed in paradox. Never has medicine been able to do so much good for so many people, yet never has the image of physicians been so poor. Never before have so many people over sixty-five or poor people had access to decent medical care; yet never before have we had an estimated 35,000,000 citizens with no access to adequate medical care.

With little imagination one could extrapolate these paradoxes of medicine to all of social progress in the civilized countries of the western world. Pockets of poverty exist in the midst of great wealth; florid racial bias still flourishes in great nations that provide unprecedented personal freedom for some of their citizens.

The golden era

When I first came upon the scene, medicine had gathered its breath for the great plunge into the golden era. We had just discovered the magic of sulfonamides and penicillin. As the only major nation that emerged from World War II with its resources and workforce virtually intact, the United States was flexing its social, political, and economic muscles. Medicine in the 1950s and 1960s rode the crest of this wave of good fortune and optimism. Funds for investigation and teaching surged from the federal cornucopia. The research community flourished, with basic scientists and clinical investigators pursuing their heart's desire. It was a heady time.

We learned about human physiology and molecular biology. New diagnostic capability emerged through remarkable technological innovation. Mechanisms of disease were tracked to their origin; we learned of the dynamics of drug action and interaction. Research was largely unstructured but productive beyond precedent. It caused a revolution in scientific medicine. Perhaps for the first time in our long and checkered history, we had learned enough to help more people than we hurt. We could distinguish: (1) self-limited, benign diseases that should be left alone or treated to relieve troublesome symptoms; (2) diseases we could treat effectively by reversing pathophysiological perturbations, relieving suffering, avoiding disability, and even preventing or delaying death; and (3) we could recognize those illnesses that remained beyond reach, and where ministrations should be limited to consolation, kindness, and prevention of dissipation of family resources in fruitless pursuit of diaphanous cures. It was a splendid, exciting, provocative era. It produced libraries of new information and armies of superb investigators and clinicians. It was medical Camelot.

But something was left out. We were so busy out hunting the lions that we forgot about skinning them and delivering the meat to the villagers. In the midst of our intellectual fervor we forgot (or did not have time to worry about) the mechanics of translating the new knowledge into clinical reality at the bedside. We simply overlooked the need to deliver our new-found intellectual riches to the people, especially the poor and the elderly.

During this period of medical ebullience, social scientists and enlightened politicians were enjoying their own particular renaissance. As I indicated earlier, they had invented Medicare and Medicaid! When they looked up from their graphs and charts, which were showing important gains for our citizens in housing, nutrition, financial security, and human dignity, they realized that medicine was not very visible. We were still cloistered in our laboratories and clinics.

Thus, if one studies the medically oriented legislation of the past two decades, one sees a ponderous pattern that represents an effort to bring the glorious advances in medical science that were derived in the 1950s and 1960s to bear on the health problems of the people.

Perhaps this is the way it had to be. Perhaps the genius of medical science lies in doing just what we did—pursue knowledge and attack it with intense, single-minded dedication. Perhaps the application of that science, the delivery of

medical care to the people, should be left to others, those experts adept at social and political manipulation and implementation.

It would seem logical, but as we shall see it is not that simple. Another factor, the astonishing cost of modern medical care, has arisen, and it threatens to dominate all other considerations. The warm benevolent winds of Medicare that arose in 1965 have become the cold whirlwinds of cost overruns in 1986. In our zeal to deliver the golden egg (health care) at a reasonable cost, we must be wary that we do not destroy the marvelous but endangered goose (education and research).

But already there is evidence of a lack of balance. There has been a shift in the intellectual and political climate, fueled primarily by serious concern about health care costs and the contribution of doctors to those costs. I have already touched on the public uneasiness with physician affluence. This is reflected in a general distrust of science and scientists. Many factors have contributed to the climate of disenchantment: the near tragedy at Three Mile Island, the scary uncontrolled tumble of Sky Lab I, which spattered the landscape of the Australian outback, the terrible disaster of Challenger, and the reports of chicanery in medical research in several of our prized citadels of scholarship, Harvard, Yale, and Stanford. This series of well-publicized misadventures and many other lesser events have exacerbated public concern about the reliability of science and scientists. And this includes physicians.

Effects on medical education

I would like to approach what is happening in medicine on several fronts: first, the impact of the new environment upon medical students, then its impact upon House Staff, and then finally how it may affect the academician and the practitioner.

For medical students the game has changed. There is strong suspicion that medicine is no longer attracting its traditional lion's share of the best and the brightest of undergraduates. The number of applicants for first-year medical school positions has declined. There are still sufficient first-year positions for fine students, but their numbers are decreasing, and there is some concern about the overall quality of candidates. Yet there is no indication that the number of medical students who cannot compete for U.S. positions and who drift to schools in the Caribbean or Mexico has diminished.

Another major problem relates to finance. Poor students and those from the minorities are finding it increasingly difficult to obtain funding for medical school. Federally guaranteed student loans have virtually dried up. The National Health Service Corps Scholarship program has been cut way back; it is almost nonexistent. The scholarship programs for the Armed Forces are already oversubscribed. With tuitions ranging in the $20,000 per year category, medicine threatens to become a club for the rich.

The decline in popularity of medicine as a career option for college students may be related to all of this. There are certainly more lucrative fields for bright young people in computers, business, even the other physical sciences. Students are not ignorant concerning the much-advertised impending decline in physician incomes, the lessening of opportunities to practice in the most desirable geographical areas, and the shrinking of options to select the specialty of one's heart's desire.

How about residents and fellows? Well, there has been no decline in the number of first-year positions across the country. In fact, there has been a slight increase this year. But there is decreasing opportunity to obtain first-class positions in the hospital or even the specialty of one's choice. The reasons for this are complex; subject for another day.

But another factor looms that threatens the very foundations of graduate medical education: the impending crisis in finance. At the present time it is estimated that between 40% and 70% (there is marked institutional variation) of the cost of graduate medical education is borne by revenues derived from patient care via Medicare Part A, which feeds into the Social Security Hospital Trust Fund. Another chunk of the subsidy comes from Blue Cross/Blue Shield and other third-party payors. The remainder comes from the states, foundations, veterans administration, and other sources.

Last year during one episode of the continuing saga of the Social Security Crisis, the Hospital Trust Fund was threatened with bankruptcy. There was mad scrambling in the Congress and at the OMB to figure out some way to salvage the fund. A fat, juicy target loomed on the horizon: postgraduate education for physicians. The OMB said, "My goodness, here we are using tax

dollars to finance the education of a group of students who will soon join the highest paid group of professionals in the world! Why should public dollars be spent on the education of doctors in training?" One might make a case that a substantial investment in the education of American doctors is appropriate to preserve a great national resource—the best health-care system in the world. But this argument stands on a slender reed when you try to sell it to a hard-nosed congressperson from a farm state where the small-acreage family farmers can no longer get loans. Or how about a congressperson from Detroit, where the shoemakers and tailors are hammering on the door when they discover that the Small Business Administration has been wiped out? Then there are other formidable numbers. The average income of a medical resident, at $25,000, is about twice the poverty level income for a family of four!

At this time, we have had a moment of respite; the House-Senate reconciliation package related to funding graduate medical education was better than we had hoped for in the prevailing climate of cost containment. We wait nervously to see what Gramm-Rudman-Hollings will bring to bear on the plan to continue to finance graduate medical education.

But there is little sympathy in Washington for the continued subsidization of graduate medical education in the traditional mode. As we struggled with this problem in the preceding months, I concocted a plan. Why not a federally financed, selective subsidy for medical students and House Staff, analogous to the National Health Service Corps? It would subsidize bright student prospects, including those from minority groups (who have little chance to obtain loans). Upon completion of medical school they would be obliged to take primary care residencies in pediatrics, internal medicine, or family practice, and a few could be encouraged to train in those subspecialties identified as areas of need. But there would be less or no subsidy for students who sought careers in fields designated as oversubscribed. Candidates who proved to be worthy and were selected would be obliged to practice on a payback basis, year for year, with no buy-out provision. Also they would be obligated to serve in less felicitous geographic areas where the need is great, perhaps to reach some of the despairing 35 million. Admittedly, this would be a controlled system, quite antithetical to the complete freedom of choice that exists at present (at least de jure). But de facto times have changed, and true "freedom of choice" no longer exists, except for those who can afford it.

There is a precedent. We created a similar program in World War II to supply physicians to the Armed Forces. There are a few grey heads in this room today, including my own, that would not be here, were it not for these war-time programs. We are not in a shooting war, but, I submit, the current situation and that looming on the horizon may justify such a draconian social solution.

The future of internal medicine

There is yet another dimension to the problem, and it will affect the future of internal medicine. It is related to changing patterns of medical care. In part this is driven by economics, but also by advances in technology. I am referring to the change in where the patients are. They are moving to the periphery, away from the acute care hospitals, the traditional focal point of all teaching in the past. This movement is changing the configuration of internal medicine at all levels.

A large measure of the charm and attraction of internal medicine is the intellectual challenge. The hot pursuit of difficult diagnosis, the exciting reward of therapeutic success in achieving a cure or alleviating suffering or preventing disability, are the life's blood of our art. The excitement of internal medicine is epitomized in the who-done-it prototype of the *New England Journal of Medicine* Clinical Pathologic Conference. It is even more challenging and far more rewarding when the exercise occurs in real life.

But such opportunities are decreasing. Patients with challenging diseases often do not remain in hospitals long enough to allow the "full-court press" of diagnostic detective work and the triumph of treatment. The pressure for rapid turnover makes this difficult. Alas, the sole exposure of many medical students and House officers to internal medicine is a rotation where they see dreadfully sick patients, often with hopeless terminal illnesses, or they tend the desperately ill ICU or CCU patients who are cared for by busy, high-powered teams of super-specialists. Students and House Staff are often thrust aside or serve as lackeys or spectators during the heat of battle. It is hardly an atmosphere conducive to making the decision to invest a lifetime in such dreary or hectic activities.

Also, almost ironically, our splendid new diagnostic tools, such as contrast radiography, endoscopy, scanners, magnetic resonance imaging, or positron emission tomography, threaten to make much of diagnosis a pushbutton operation that is much swifter and easier, but at the same time perhaps less intellectually challenging than in the past, when reliance on laboriously wrought history, meticulously performed physical examination, and judiciously selected laboratory tests provided the building blocks that were the principal sources of diagnostic information. I have exaggerated to make a point. For the most part the challenge still remains; it may have to be pursued in the community hospital, the ambulatory clinic, even the physician's office. Here is where the challenging patients will be found; here is where the student and House Officer and teacher of the future will be obliged to follow. Clinical education must follow the patient.

I will not discuss the problem that exists in some medical schools where the junior faculty member finds himself or herself obliged to spend 40% to 50% of precious time in the faculty practice plan in order to generate income for the department to help pay salaries. This means 40% to 50% less time to devote to teaching and research. For many it is not a satisfactory professional life style. "It is not what I bargained for," one unhappy instructor told me, "an insecure foot stuck in each world—practice and academe." If one lives with the sense of doing a half-baked job in both areas, the decision to remain in academic medicine may hang in precarious balance.

As I have indicated, for those contemplating a career in research other problems exist beside the burden of indebtedness. Although this year, funding for NIH was more generous than some of us had anticipated in this era of the great deficit, the future is uncertain. We seem to be holding our own at present, but the budget deficit and Gramm-Rudman implications still loom ominously on the horizon.

As teachers and leaders we must accommodate these changes. We must bend every effort to retain or recapture the intellectual excitement of internal medicine, or our world will soon vanish.

How about those in practice? We are familiar with the freeze on physician fees. We know of the hardship this had created on some general internists and family physicians who rely predominantly on Medicare and Medicaid patients for income. We also know that practice opportunities are decreasing. We are told that by 1990 there will be a surplus of physicians, but this varies according to geographical site and specialty. There are probably too many psychiatrists in Beverly Hills and too many cardiologists in Boston, but certainly not enough primary care internists in Watts, Chinle in the Navajo Nation, or the Mississippi delta. Gross numbers represent a simplistic generalization to me; the country is not a homogeneous mass of people. My scheme for some version of a National Health Service Corps incentive plan would help solve the distribution problem.

We are witnessing the emergence of new and different modes of practice. Two major evolutionary events have occurred with virtual simultaneity, and synergistically they are changing the face of medical practice. The corporate giants of America awoke one day to realize that they were in a struggle for survival in the international marketplace. Their products were priced too high. They were looking at production costs. Then they discovered that the retirement benefits they were paying ex-employees had become extraordinary, and a large chunk of the increase consisted of health care benefits. When they added these numbers to the health care benefits they were providing current employees, they were astonished. They had never applied cost-effectiveness analysis to health care benefits; such entitlements were an inviolate component of every union negotiating package. Health care benefits were enshrined, or they had been. Now management began to take a tough look, and soon they realized they had big problems. The cost of having a heart attack in New York was twice as much as in Mobile. The soaring curve of expenses bore no relationship to the flat or declining curve of productivity or absenteeism. They found it difficult to understand the discrepancy, where the money was going and why costs had risen so remarkably and so variably.

So, corporate boards began to scrutinize this area that had been untouchable. After considerable study they realized that there were ways to get more for their money; one obvious device was to make discount deals with health care providers: HMOs, IPAs, and PPOs.

Well, it was just a short step to the second event. Can't you hear it now in the corporate board room?

EXECUTIVE A: Gentlemen, we've

managed to make a deal with the XYZ HMO. They will provide total care for our employees at half of what it would cost us on the (fee-for-service) market. By offering options, about half of our people have taken plans with co-payments and deductibles, and others have reduced their coverage to take the difference in cash or retirement benefits. We'll see how it works out.

EXECUTIVE B: You know, that sounds like good business.

EXECUTIVE A: You bet it is. Did you know that medical care consumes about 11% of the GNP?

EXECUTIVE B: Why shouldn't we get a piece of that action? The old man says 'diversify,' so why don't we take a crack at the health care industry? Why don't we set up our own insurance company or buy an HMO? Our other corporations already produce drugs and linens and ambulance helicopters.

And so was born vertical integration. Medicine was discovered by big business. The giant hospital chains taught us the term "horizontal integration," when the hospital corporation owns the acute care hospital, ambulatory clinics, satellite emergency centers, long-term care facilities, surgi-centers, and the mobile CT scan vans, and subsidizes doctors in their offices. And soon, some of the larger piranhas will gobble up the smaller piranhas. They will produce their own bolts, bandages, buildings, ambulances, food service, janitorial service, laundry, etc. And to staff this empire they will hire their own doctors, nurses, administrators, technicians, ambulance drivers, cooks, clerks, and bottle washers.

Paul Ellwood has predicted that by 2000, some 20 "supermeds," vertically and horizontally integrated, will emerge in different quadrants of the country. Who will be the inheritors of the health care delivery system? Sears, Metropolitan, IBM, General Motors, HCA, or Cleveland Clinic?

Are we looking into the distant future? Hardly. Already the prepaid practice plans are growing rapidly in all sections of the country. In Minneapolis and Los Angeles almost 30–40% of all patients are already enrolled in HMOs and PPOs. It is predictable that this trend will continue. Each year 15% of patients are joining prepaid plans. By current estimates, by 2000 some 120 million citizens and 127,000 physicians will be enrolled in prepaid plans. That is 106 salaried physicians per 100,000 enrollees. Meanwhile in the fee-for-service community, physician density will be three times greater, all scrambling for roughly the same number of patients as exist in the prepaid pool. There will be a doctor:patient ratio of 100:100,000 in the prepaid plans, and 300:100,000 in the fee-for-service system.

It takes no crystal ball to predict that competition within the fee-for-service area will be severe, and that most physicians will not be able to survive the economic squeeze from prepaid plans in the competition for patients. Fee-for-service may well become a luxury of the rich. There will always be some enterprising outstanding physicians and institutions who will operate outside the mainstream, who are good enough to survive and stand alone—perhaps with a foot in each world, part prepaid and part fee-for-service. But it is probable that within ten years the majority of American physicians will be salaried.

I will not discuss the issue of quality in the new system. I have not figured out a way to predict the impact of "gatekeepers," and how they will handle the economic pressure that tempts them to be sparing in calling for consultations outside the HMO or authorizing the admission of a patient to the hospital. Both actions extract dollars from the HMO pool, leaving less to be divided up at the end of the year. The gatekeeper may take on the appearance of Horatio at the bridge.

Lean diagnostic and therapeutic thinking may be quite salutary, a thoughtful intellectual exercise. But I am troubled because economic considerations should not insinuate their way into medical decision making. And doctors are only human. But lest we judge too quickly, we must await realistic outcome studies to assess the comparison of different methods of health care delivery.

And practice is changing in other ways. The competition will not be confined to physicians. It will become fierce among all health care practitioners. We are beginning to witness the "marketplace phenomenon": open competition among all sorts of self-declared "healers," with all sorts of credentials, all selling their particular brand of health care. The shingles of acupuncturists will hang beside those of allergists, naturopaths beside neurosurgeons, and chiropractors beside cardiologists—all in display in the marketplace of medicine. Consumers will be compelled to make serious decisions about choice of healers on the basis of Madison Avenue hype and their own

levels of medical sophistication. "Caveat emptor" will resound throughout the land.

There is yet another fascinating development streaking across the landscape of medicine that will have far-reaching implications for every practitioner. The computer era is dawning in medicine. Despite the uneasiness of my generation, an undeniable fact is that within five years the complexity of interacting with a computer console will disappear. The intimidation of the keyboard will vanish when telephone-simple or even voice-activated instruments will provide easy access to the wisdom of the world. Vast libraries of information will be at our fingertips, available in real time. To use the computer will be as easy as using a telephone. Cunning micro devices accompanied by laser disc displays will provide high-resolution pictures and graphs in living color. Print journalism will be for archives and more reflective reading.

Thus the physician or the nurse practitioner in Point Barrow, Alaska or Kaunakakai, Molokai will have the capability to provide a level of care unprecedented in the annals of medicine. The impact this will have on every aspect of future medical practice is inestimable.

Another troubling dimension of the private practice of medicine is the continuing problem of physician liability. As long as the United States continues to embrace the tort system for medical liability and to permit an unrestricted contingency fee system, with no caps on awards, and no system of meaningful arbitration, we will remain in travail. We physicians are not without complicity in this melancholy drama. We are guilty of cavalier attitudes in our dealings with patients. Some of this stems from unadorned professional arrogance, but more often it is due to carelessness. Some of us keep terrible or illegible records; others fail to follow up critical diagnostic laboratory clues; and some are slipshod in prescribing habits. Also, we have done a lousy job of policing our incompetents.

So despite the avarice of some opportunist lawyers, we have contributed to the present dilemma. We do have patients who are the victims of frank medical blunders and such patients deserve their day in court. But all this litigation must be conducted in a more rational atmosphere. We must get our own house in order as we seek some system of fair and binding arbitration, some limit on awards for death and disability, some limitation on contingency fees, a fair statute of limitations, and a modification of the tort system to eliminate truly unworthy suits, while ensuring a mechanism to identify those cases where true malpractice has occurred.

Certainly the contingency fee has a rightful place within the law as a vehicle for poor people who have a legitimate claim. But it must cease to be exploited as a fishing license by some lawyers. There is a Senate bill sponsored by Senator Orrin Hatch that considers many of these aspects. It has plenty of warts, but it represents a step in the right direction.

The health care system of the United States is probably the best in the world. But there will always be inequities and dissatisfaction. That is the nature of a free society. There will always be income differentials; there will always be some people with greater intellectual endowment; there will always be cheating and greed, just as there will always be honesty and generosity. Not everyone can drive a medical Cadillac, but no one should be forced to walk.

Above all else, regardless of anything the future may hold, we physicians must reaffirm our pledge to our forebears and reaffirm our role as the primary advocate of the patient. I am convinced that the practice of internal medicine will survive these turbulent times. It will emerge stronger. Our training programs will be tailored to meet current and future needs. We will derive a proper proportion of academic internists (to continue to inspire our medical young) and general internists (to stand at the head of the health care team). We will generate a reasonable number of subspecialists (there will always be sicker patients with special problems) and a growing number of "hobbyists" (who will serve as general internists with a special area of expertise). I envision clusters of these hobbyists who will populate our smaller towns and suburban areas in a variety of practice configurations, offering superb primary and secondary care. Physicians in such groups will provide intellectual stimulation to each other and all those around them.

I am convinced that the very survival of medicine as a discipline depends on the continued vigor and capability of medicine to adapt to the changing environment. All of us, especially program directors, must realize that we are being called upon to accept new responsibility—a social responsibility, in addition to our traditional commitment to scientific excellence. It means that our specialty and subspecialty programs must be

tailored—cut back or expanded—to meet the needs of the people.

I am an optimist. I believe we are wise enough, as a nation and as individuals, to galvanize our intellectual resources and create a system that will provide sound medical care for all of our people and at a price we can afford. But the time has come when we physicians must move beyond our wards and clinics and laboratories, and direct a portion of our considerable energies to economic and social problems with all the vigor, dedication, and genius that we apply to solving the great enigmas of medicine. We must seize the future by planning for rational change and not allow events to roll over us and inhibit our ability to care for our patients.

The ultimate purpose of all our exertions and exhortations is to seek enlightened medical care for all of our citizens. It is a goal that all of us, physicians and legislators and all responsible citizens, must strive to attain.

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