29 January 1971, Volume 171, Number 3969 SCIENCE

Higher Education and the Nation's Health

Before the turn of this century, the American Medical Association (AMA) had begun to root out quacks and nostrum producers and to expose the deficiencies of proprietary interests in medical education. With AMA support, the Carnegie Foundation commissioned Abraham Flexner to report on the state of medical education. His recommendations in 1910 revolutionized medical education by establishing it as a full and proper function of the university.* Proprietary medical schools were driven out of business, and the AMA's Council on Medical Education helped to set and enforce the new standards of accreditation.

Advances in medical science and technology have proven the wisdom of the Flexner Report. These successes have produced rising expectations, and rising costs have inevitably followed. Nonetheless, health statistics belie our massive expenditures on health services. We find ourselves with a severe shortage of medical manpower and with an inability to utilize optimally our hard-won knowledge. A profound disarray characterizes the financing of universities and medical schools. A renascence of anti-intellectualism (or anti-science) is now compounding the problem.

The Carnegie Foundation has once again entered the fray. Its report† notes that "the Flexner, or *research* model" with all its tremendous benefits has produced two major weaknesses: (i) expensive reduplication of scientific effort between medical school and parent university; and (ii) neglect of the problems of utilizing medical knowledge and of the public issues of cost, quality, and accessibility of health services. The report applauds recent efforts of some medical schools to extend themselves into the community to develop new "health care delivery models" and to develop "integrated science models" in the university. It recognizes the need for increased numbers of doctors, dentists, and allied health personnel, and for regionalization of health services.

The report recommends the development of more university health science centers and of 126 area health education centers that would be affiliated with the health science centers for the purpose of providing regional training and of making high-quality services available. It calls for increased federal and state support for private medical schools but suggests that costs can be reduced and manpower increased by reducing medical school requirements from 4 to 3 years and doing the same for residency training. In addition, combining science in the medical school with that on the university campus, reducing the faculty to student ratio, admitting two classes a year, teaching during the summer, and having a minimum class size of 100 to effect economies of scale, and, finally, increasing the numbers of allied health personnel to increase the productivity of physicans are rational and laudable recommendations.

Unfortunately, the report has been perceived as blaming scientific advance for the social problems surrounding the delivery of health services. This nation would be better advised to heed the caveat that knowledge does indeed cause trouble but that ignorance causes far more.

Exceptions must be taken to some parts, but, overall, the report is comprehensive and rational. We have enough reports. We must have action. Medical and other university faculties, practicing physicians, and responsive state and federal governments must all play a part in the resolution of the issues. The time may be shorter than we think.—JOHN H. KNOWLES, *General Director, Massachusetts General Hospital, Boston*

* A. Flexner, *Medical Education in the United States and Canada*, A Report to the Carnegie Foundation for the Advancement of Teaching (Merrymount Press, Boston, 1910).

† *Higher Education and the Nation's Health: Policies for Medical and Dental Education*, A Special Report and Recommendations by the Carnegie Commission on Higher Education (McGraw-Hill, New York, 1970).

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Science **171** (3969), 337.
DOI: 10.1126/science.171.3969.337