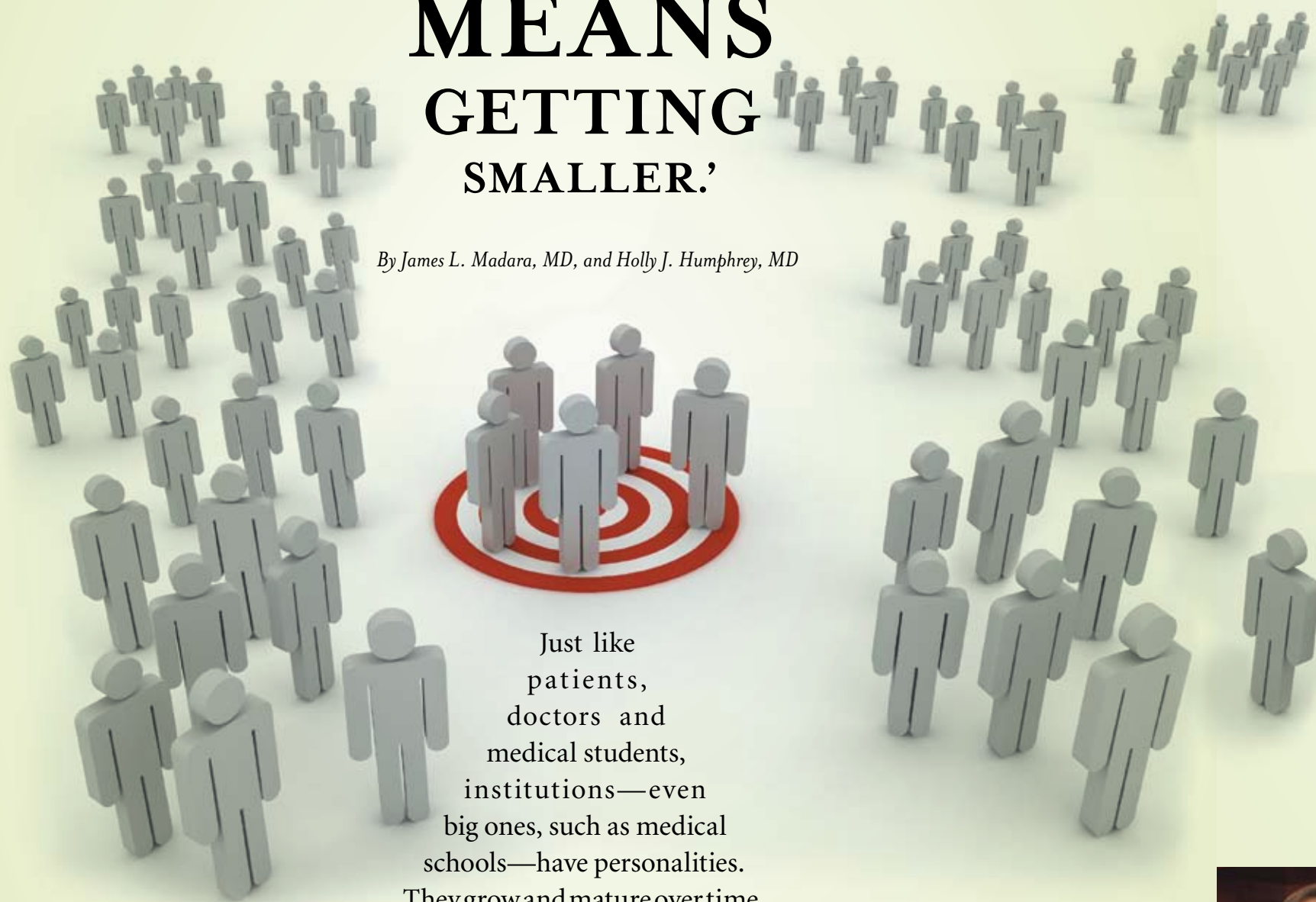


# 'FOR US, PROGRESS MEANS GETTING SMALLER.'

By James L. Madara, MD, and Holly J. Humphrey, MD



Just like patients, doctors and medical students, institutions—even big ones, such as medical schools—have personalities. They grow and mature overtime, in response to internal inspiration or external pressure. But a core of beliefs and practices should determine how any institution functions. Moving too far away from that core means losing sight of your mission.

## THE UNIVERSITY OF CHICAGO PRITZKER SCHOOL OF MEDICINE HAS ALWAYS BEEN COMPARATIVELY SMALL. IT IS WHO WE ARE.



Predicting a physician shortage, the Association of American Medical Colleges and others have been urging medical schools to train 30 percent more physicians by 2015. In response, more than eight out of 10 schools have vowed to increase class size. Many have already done so, but not us.

The University of Chicago Pritzker School of Medicine has always been comparatively small. It is who we are.

Fifty years ago, the University of Chicago enrolled 55 to 60 new medical students each year. Most of them went on to combine the practice of medicine with distinguished research and teaching careers.

In the 1960s and '70s, however, a series of federal incentives put pressure on all medical schools to increase enrollment, so the University of Chicago gradually raised its class size to 104 new students per year. But in fall 2009, despite being exhorted to grow, we will scale back to 88.

This decision is based entirely on our mission to train outstanding physician-scientists and to develop leaders in academic medicine. Our focus is not on training more doctors but better doctors. For us, progress means getting smaller.

Instead of increasing the number of students, we are choosing to increase student-faculty interaction. Instead of big lecture classes, we are choosing small-group, hands-on learning under the direct mentorship of our full-time faculty. Our students not only will learn about the cutting edge of biomedical science, they will help make discoveries, learn how to translate that knowledge into patient care and acquire—through example, experience and osmosis—the moral foundation of the profession. These are the kinds of doctors our patients deserve.

While it's easy enough to make a big lecture class bigger, it is more challenging to go the other way, to take a lecture class with 50 or 100 students and break it up into smaller groups—one professor and, say, five to eight students. This new emphasis on personal instruction,

intense faculty mentorship and a hands-on approach to teaching places extraordinary demands on our faculty—a bit more, perhaps, than we are equipped to handle with 104 new students a year.

Others share our concerns about class size. A recent survey published in *Academic Medicine* found most medical schools were thinking about the consequences of increasing class size, which “clearly has the potential to adversely affect student education, faculty recruitment, and faculty morale.”

So we will now devote the same educational resources and financial support to fewer students. We will increase student-faculty contact and, in the process, restore to medical education some of the personal bonds that may have been lost because of pressures on faculty time.

What about our obligation to increase the physician workforce? As scientists, we have yet to be convinced of the reality of this looming shortage. The institutions that train new doctors—and collect tuition for it—have been predicting such a shortfall for decades. Yet the U.S. physician supply is at an all-time high, up from 200 doctors per 100,000 people in 1980 to a predicted 293 in 2010.

Having more than 40 percent more doctors per capita has not led to better care, easier access or improved patient satisfaction, noted Dartmouth's David C. Goodman, MD, MS, and Elliott S. Fisher, MD, MPH, in the April 17, 2008, issue of the *New England Journal of Medicine*. They argue that by simply adding physicians, we are treating the symptoms while ignoring the disease: “a largely disorganized and fragmented delivery system, characterized by lack of coordination, incomplete patient information, poor communication, uneven quality and rising costs.” Training more physicians, they write, may only worsen existing problems and potentially create new ones.

We think it is less important how many doctors we produce and more important what those doctors do—and where they do it. Neither the Hamptons, nor South Beach, nor Beverly Hills needs another cosmetic surgeon. But the 1.1 million residents of the South Side of Chicago could benefit from a few more

doctors with an interest in chronic disease. This radically underserved community—despite being just a few miles from the largest public medical school in the country—has extremely high rates of hypertension, diabetes and asthma, all largely untreated.

When a person is 32 years old, \$150,000 in debt and about to start a first real job, it's hard for even the most compassionate doctor to commit to a career caring for the poor. But having fewer students, and the same financial aid resources, will enable us to graduate new doctors with about 40 percent less debt.

We also have taken an innovative next step. Beginning this fall, we will encourage our graduates to return to the underserved communities of the South Side of Chicago to practice medicine by providing four years of financial support—enough to pay off the average graduate's debt. That program, Repayment for Education to Alumni in Community Health (REACH), brings Pritzker alumni back to the neighborhood where they learned their craft, after they complete their residencies.

Although they could make other choices and earn higher salaries, we want our graduates to follow their passions, not their pocketbooks. This program will give carefully selected doctors who are just starting their careers the opportunity to do just that, without the burden of college and medical school loans.

When she first heard about this project, fourth-year medical student Mia Lozada wrote: “When thinking about my future career I went with my heart”—despite a substantial loan debt looming over her. Primary care “may not reap huge financial rewards,” she added, “but it is where I feel I can make the most impact with this education that I've been so lucky to receive.”

We want all our graduates to emerge feeling lucky, like Dr. Lozada, and confident that they have the power to make an impact and the freedom to follow their hearts. That's ultimately why, despite constant pressure to move in the opposite direction, we're getting smaller rather than bigger. It is who we are and who we are meant to be.



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