Chapter 1
Getting In

From the dedication page:

This book is dedicated to those Chilean health workers who struggled to transform their society and died at the hands of the government that took power in the coup of September 11, 1973.

Where do doctors come from? Or, who goes to medical school and how do they get there?

My high school class in Winnipeg might serve as an example. Geographically, the school straddled middle-class and working-class districts. My own class, however, comprised thirty students with the highest grades in the school: needless to say, we were all from the "right side of the tracks." Now, as I look back on that class, I realize that the aspirations of the students were remarkably uniform. Coming mainly from middle-class families, we never had any doubts that our paths would lead straight through one of the professions. All of us were encouraged by our parents, overtly or otherwise, in this direction. Some made minor modifications in their ambitions, by choice or necessity, but the general outcome of the pursuit of career in that class was never really in doubt. At last count, we had produced three academics, five physicians, and six lawyers.

During high school I knew of several students in my class who were intent on becoming physicians to the exclusion of all else (they were all male; I do not recall any women sharing this "dream"). One of them, for instance, talked of little else during his high school years, in spite of not being particularly proficient in science studies. It seemed he could not imagine himself as becoming anything else; his older brother was already a doctor. "Do you think I'll get into medicine?" he would ask. "I don't know what I'll do if I don't. There's nothing else I want to be."

Three other students in my class who had medical school ambitions were themselves the sons of physicians. One had rather mediocre grades; it turned out he had to apply two or three times before getting in. Another had quite broad interests; he later dropped out of medical school after a week, drifted around a bit, and ended up as a lawyer. The third never had any doubts about where he was heading and is now a cardiologist.

Is this middle-class scenario in which I partook representative?

In general, medical students in North America are recruited from the economically privileged sectors of society. Over a decade ago, Canada's Royal Commission on Health Services reported that 54.4 per cent of general practitioners and 65.8 per cent of specialists in Canada, at the time of their entry into university, had fathers with professional or managerial occupations. In addition, 73 per cent of all physicians had fathers whose occupational class, according to one index, was among the top 17 per cent in the country; 15 per cent of Canadian physicians have doctors for parents.[1] The pattern is similar in the United States, where 58 per cent of physicians come from professional or managerial backgrounds and about 17 per cent have physician parents.[2]

Of 135 students in my medical course at McGill University, Montreal, I knew ten (and there were probably more) whose fathers were physicians. There were at least three in the class who were children of the elite (one was the son of the president of a large trust company, another was the son of the president of a large pharmaceutical company, and the third was the daughter of the President of Liberia). Only a handful of students were from working-class families, and just one from a family that was genuinely poor. The rest were from the various strata of the middle class and upwards. In this sense, we were probably representative of most medical school rosters today. We had a "relatively homogeneous social background,"[3] and few of us would have been thought destined for "lesser" careers.

Enthusiastic, hard working, and bright, without a doubt, but the collegians who made it into medical school were of a different and finer slice of society than were those who did not, just as the movement from high school to college left behind many of the children of the working class. What was perhaps most remarkable about us (and about those with whom we competed for admission) was the extent to which it mattered that we get in.

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1 S. Judek, *Medical Manpower in Canada: Royal Commission on Health Services* (Ottawa: Queen's Printer, 1964).

2 H.H. Gee, "The student's view of the medical school admissions process," in H.H. Gee, J.T. Cowles, "The Appraisal of Applicants to Medical School," *Journal of Medical Education* 32, no. 10, part 2 (1957):110–52; and H.C. Gough, W.B. Hall, "A comparison of medical students from Jedical and nonmedical families," *Journal of Medical Education* 52 (1977): 541–47.

3 B.R. Blishen, *Doctors and Doctrines* (Toronto: University of Toronto Press, 1969), 33.

The scramble for admission

Certainly one of the reasons for wanting to follow a medical career is an economic one: as one admissions officer said, "Medicine is almost the only career that offers total security." In fact, medicine is one of the very few professions in our society in which the worker has absolute job security, at least in the last couple of decades. Physicians can always find work, whatever their clients, fellow workers, and even bosses (when they exist) think of them. Physicians are also respected in the community in a way that few other people are. There is ample (some would say excessive) economic return for their labours; a doctor's income is sufficient to provide an effective buffer against economic downturns, stagflation, and all the rest. The work itself is often gratifying, interesting, and stimulating. All these factors combine to make the life of "Doctor" an oasis or at least the mirage of one in a desert of unhappy work and life experiences. All students entering medical school are aware of this.

It is not really surprising, then, that students from privileged backgrounds end up in this kind of professional career. The expectations of parents, for one thing, play an important role. My parents never openly urged me to go to medical school, but they did discourage a career in journalism. I suppose it was my acceptance of a set of values stressing economic security that made it probable I would end up in something like medicine.

Once the decision to attend a medical school is made, the process of applying is tortuous. McGill had an officer whose full-time job was to advise students about entering medical schools. If such a person is not around to tell students how to go about applying and to offer a realistic assessment of their prospects, the situation can be even more anxiety-provoking than it is. In order to apply to just one medical school, students have to complete the appropriate application forms, pay a fee, forward their undergraduate grades, write a standardized quiz (the Medical College Admission Test), arrange for letters of recommendation to be sent and, finally, submit to one or more interviews.

Then too, because acceptance at any one medical school is rarely guaranteed, almost all students serious about applying submit applications to several. Not infrequently one encounters the determined character who has applied to each of the more than 100 schools in North America. This multiple application process of course builds up the numbers considered for entrance at different universities and thereby makes the apparent odds longer for any one student at any one particular school. This only increases the applicants' anxiety and provokes even more applications. At McGill, some three thousand students (and the figure is still climbing) apply each year for the one hundred and sixty positions open, so the competition is intense.[4]

The scramble for admissions at McGill is embodied in a "pre-medical society" made up of students pragmatically working together, covering all the angles in their bids to become physicians. These students develop contacts that will later be useful as references; they learn of the obstacles in the admissions ordeal; perhaps most important, they structure this critical period in their lives so they can at least draw strength from the experience of others.

It is all a serious business: students who engage in premedical societies and other rituals intended to improve their chances of getting in would probably do so even if the activity made no difference to their chances. Persons who call themselves premedical students, whatever their prospects for subsequent acceptance, are engaged in a kind of dance of destiny. By acting out the role of premedical student, they hope to identify themselves as such. If they bow early and often before the altar of medicine, they may just obtain the salvation that they associate with admission to medical school and a medical career.

How to get in

What factors govern the student's chances of getting in?

"Only two things really matter: marks and pull," one member of McGill's admissions committee told me.

Academic performance is perhaps the most important determinant of a student's chances. And while this particular determinant may not discriminate in favour of the privileged few, it does tend to militate against those who, for one reason or another, have not excelled in their undergraduate courses.

Excelling, by present-day medical school standards, means that the individual must obtain top marks consistently throughout the undergraduate years. The competition for places in the medical class is so fierce that an admissions committee doesn't have to settle for anyone who is, by this criterion, second best. That means students who have, for instance, taken time out to question their role in society and place in the university, allowing "performance" to suffer as a result, or who have changed interests (and courses) in midstream, may be at a disadvantage: they may have failed to demonstrate that they are above all "good students" and "know what they want."

Many students, on the other hand, faithfully tailor their undergraduate programme to appeal to members of admissions committees. Some deliberately choose not to take courses in the humanities that otherwise interest them, precisely because they fear not obtaining the obligatory "A" grade.[5]

4 In 1976, 42,155 students submitted 372,282 applications in competition for 15,774 positions in American medical schools. Thus has the market become much tighter: in 1962, 15,847 students submitted 59,054 applications for 8959 positions. (See "Medical Education in the United States," *Journal of the American Medical Association* 238 [1977]: 2770.)

5 S.C. Wolf, "I can't afford a B," *New England Journal of Medicine* 299 (1978): 949–50.

This obsession with grades sometimes leads to strange situations. One professor, not at all atypical, reports that fifty students invariably line up outside his office the day after he posts the grades in his biology course; the students hope to garner the extra point or two that might make the difference between an acceptable and an inadequate average. These students are pursuing not an education, but a position in a medical school class, and their undergraduate professors are, in a very real sense, sitting in judgement as to whether or not their disciples should be allowed to go on to the coveted goal. Understandably, many professors are unhappy with this role.

The other factor in the entrance equation is "pull" and there is no doubt that some people have a great deal more going for them than others. One McGill admissions committee member reports having received a telephone call from the Prime Minister of Canada urging that a particular student be accepted. Another tells of an anxious father who phoned and said, "If you accept my son, I'll deposit $10,000 in your bank account tomorrow." Occasionally such incidents seep into public awareness, creating shock and indignation, as when it was reported that at least eight students gained admission to the medical school at the University of California's Davis campus because of wealth or good connections.[6]

In both of the McGill cases, I was told, the intervention did not influence the committee deliberations. Nevertheless, there are certainly some institutions where pressure, perhaps more subtly applied, has some effect on the candidate's chances. Reflecting on this, one admissions committee member remarked: "It is often difficult to say no to your colleagues."

Cronyism – favouring the sons of fellow physicians, of university professors, and of others the committee member knows – is probably responsible, at least in part, for the fact that fifteen per cent of Canadian physicians and seventeen per cent of American physicians have physician parents. Certainly, in comparison with the proportion of physicians in the population, much larger numbers of physicians' children are getting into medical school than would be likely in an entirely meritocratic system.

How not to get in

Students from backgrounds that do not encourage academic achievement, or from social situations in which university attendance (and, even more, professional ambition) is not the norm, or from backgrounds in which, for various reasons, the preparation for university has been inadequate, will be at a serious disadvantage in the competition for positions in the medical class, even if they do apply.[7]

The priority given to academic standing is a form of discrimination against the poor. One expression of this is underrepresentation in medical schools of those minorities who are over-represented in the lower socio-economic groups. There were no black Canadians or black Americans in my class. (There were a few Africans, all from wealthy families.) There were also no Native people, in spite of the fact that our school had been very self-congratulatory about its efforts to supply medical personnel to the Canadian north, which receives such inadequate medical service.

Some groups have begun to agitate for greater representation in medical classes. American blacks, who had been virtually shut out of white medical schools (there are two black schools: Howard and Meharry), have been admitted in growing numbers in the last few years.[8] As yet, no such organized efforts have been undertaken to better represent the poor.[9] Most positions at medical schools remain the preserve of the meritocracy, which is often resentful of even the token concessions made to minorities. ("I can only compete for 115 of 130 positions in the Harvard medical class," a Boston area student told me.) Even the existing program, however, has been straining the American legal and constitutional apparatus. An applicant rejected by a medical school in California has successfully contended before the courts that he was "improperly denied" a place in medical school when positions were given to "less qualified" minority applicants.[10]

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6 *Los Angeles Times*, 14 July 1976, pII-1.

7 Amongst applicants to Canadian medical schools in 1968, 37.2 per cent had fathers who had attended university, while at the same time less than ten per cent of the total population aged 40 to 69 had attended university. See R.N. Jones, D.G. Fish, "Social characteristics of applicants to Canadian medical schools," *Journal of Medical Education* 45 [1970]: 918–28.

8 "Medical Education in the United States," *Journal of the American Medical Association* 238 (1977): 2771–72.

9 It is important to note that the introduction of larger numbers of people from the lower echelons of society is unlikely to make the medical profession any less conservative or more socially conscious. What data exist suggest that, if anything, the contrary may be true when no other aspects of the selection process are altered. See J. Colombotos, "Social origins and the ideology of physicians: A study of the effects of early socialization," *Journal of Health and Social Behaviour* 10 [1969]: 16–29.

10 *Los Angeles Times*, 9 November 1976 (editorial), pII-4. The case of *The Regents of the University of California vs. Allan Bukke* was considered by many to be among the most important matters to come before the United States Supreme Court since World War Two. These are two aspects of the case that are particularly relevant to the present inquiry. The first is that although "affirmative action" programmes have affected large numbers of people in many productive sectors, it is in relation to medical school admissions,which concern relatively few, that the monumental court battle came (and attracted so much attention). The second aspect is the rationalization provided by supporters of affirmative action. Ronald Dworkin, Professor of Jurisprudence at Oxford University, who has taught at Yale and New York University Law Schools, is himself a supporter of "affirmative action" in medical schools. He is probably speaking for much of the liberal establishment when he argues that "America will continue to be pervaded by racial divisions as long as the most lucrative, satisfying and important careers remain the prerogative of the mem-

Another practice of medical school admissions committees is to limit severely the number of places open to foreigners, Very few medical schools admit any foreigners at all. McGill is one exception. My class had 32 non-Canadians, almost 25 per cent of the total students. Of these, however, 20 were Americans and, of the remaining 12, virtually all were from families wealthy in their native lands. In 1972, a total of 240 foreign nationals were admitted to American medical schools, an average of less than three per school. There were, on the other hand, 3715 Americans registered at all levels in overseas medical schools the same year.[11] Many of these eventually return to practise in the United States; the training of a physician is an expensive proposition, and this amounts, in effect, to a subsidization of North American medical education by less prosperous countries.[12]

Political discrimination is undoubtedly widespread in the selection of the few foreigners who do get into the medical schools. One member of my class, who was from the Far East, was asked during one of four pre-admission interviews at McGill what he thought of the Domino Theory! An interviewer at the University of Southern California asked the same applicant what side he would fight for in a war between the United States and China.

But the political views of non-foreign students may be a factor in admissions as well. Although politics did not come up in my own interview, some of my classmates reported that they were questioned about their views on universal health insurance (Medicare) and the Saskatchewan doctors' strike; these questions came from committee members who seemed antagonistic to societal interventions in the delivery of medical care. They may have felt they had good reason: the class prior to ours had included a number of leftward-leaning individuals who had given headaches to the faculty by questioning health care priorities and the medical school curriculum. This behaviour on the part of the usually docile students upset many faculty members; they considered it a mistake to have allowed such people into medical school. The head of the admissions committee was relieved of his responsibilities, reportedly because of this "error." Needless to say, the admissions committee was more careful in its selections for my year, resulting in a much more conservative class. At a time when campus radicalism was at its peak, the number of "progressive" minds in my class was relatively small.[13]

One innovation in admissions policy the year I applied was a marked increase in the number of French Canadians accepted. In the three previous years a total of seven had been admitted; in my year there were eighteen. Some of the Francophone members of the class reported that they had three or four separate interviews during the admissions process. No Anglophone student I have spoken to had this experience.

There had been some agitation around that time to convert the university to French-language use. "We were careful to choose French boys who were quite conservative," a committee member told me. "We didn't want any trouble."

Women and admissions

Yet another form of discrimination restricts the number of women who are permitted to embark on medical training, and the struggle of women to obtain a significant proportion of positions in medical classes in North American schools has been arduous. Only Spain has a smaller proportion of female to male physicians than have Canada and the United States.[14] In recent years there has been an upswing in female enrolment but this has not yet made much of a dent in the physician work force.[15]

Of course at one time things were much worse. McGill did not graduate any women physicians at all until 1922.[16] Harvard's medical school, even worse, did not graduate a woman until 1949.[17] The Johns Hopkins Medical School in Baltimore was an exception: it admitted women from its founding in 1889, apparently motivated by a substantial donation from four Baltimore women "under the expressed condition that women be admitted . . . on an equal footing with men."[18]

An early incident at McGill is indicative of the pressures against female enrolment.[19] In 1888, a woman named Grace Ritchie was the valedictorian for the first group of women to graduate from the McGill Arts faculty. But prior to the commencement ceremony her address was censored by the prin-

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bers of the white race, while others feel themselves systematically excluded from a professional and social elite." (See "Why Bakke has no case", *New York Review of Books* 24, no. 18 [10 November 1977]: 11–15.) What is thus revealed is the objective of some minority admission proponents to generalize the myth that anyone can make it in America!

11 "Medical Education in the United States, 1972–3," *Journal of the American Medical Association* 226 (1973): 913–14.

12 *New York Times*, 14 November 1976, 26.

13 Why would the admissions committee have felt obliged to "crack down" on left-wing political activists? Were its members defending their own class interests? There is considerable doubt that middle-class medical students, even when turned on politically, could represent any serious threat to the established order (although this may not have been apparent). A more likely explanation is that having such people around made life more complicated – they were troublesome. It made administrative sense to keep them out.

14 V. Navarro, "Women in health care," *New England Journal of Medicine* 292 (1975): 398–402.

15 M.C. Howell, "What medical schools teach about women," *New England Journal of Medicine* 291 (1974): 304–7.

16 J. Abourbih, "The admission of women to the McGill medical school," *McGill Medical Journal* 40, no. 2, 3 (1971): 22–24.

17 F.J. Ingelfinger, "Doctor women," *New England Journal of Medicine* 291 (1974): 303–4.

18 A Chesney, *The Johns Hopkins School of Medicine: A Chronicle*, vol. 1, chap. 8 (Baltimore: Johns Hopkins Press, 1943).

19 The account that follows is from J. Abourbih, op.cit.

cipal of the university. She included the censored remarks in her delivered version nevertheless, calling for admission of women to the Faculty of Medicine. This apparent outrage brought cries of "Never!" and "Shame!" from some of the medical students present.[20]

Among the obstacles that women had to overcome were medical educators with serious doubts about the readiness of the community to accept female physicians. William Osler, an eminent physician of the late nineteenth and early twentieth centuries considered by many as the father of modern internal medicine, dealt with this "problem" in his presidential address to the Canadian Medical Association, at a time when he was working at the Montreal General Hospital:

> It is useless manufacturing articles for which there is no market, and in Canada the people have not yet reached the condition in which the lady doctor finds a suitable environment. Look at the facts as they are, even the larger cities can only support one or two; in fact, Quebec and Montreal have none, and in the smaller town and villages of this country, she would starve.[21]

During the decade after Osler's speech, a few women did come to practise medicine in the province of Quebec, but not because of any benevolence or openmindedness on the part of McGill. Around 1890, just after an initiative to get women into McGill had failed, a rival school, Bishop's University, started to admit women and eventually graduated two. This enlightened policy was cut short in 1900, however, when the Montreal General Hospital amended its bylaws to preclude the training of women medical students on its wards, thereby depriving the women of Bishop's of their main source of clinical experience. Women were finally admitted at McGill in 1918, when most prospective male physicians were off at war.

Things have improved somewhat since that unbelievable era; eighteen of my classmates were women – about thirteen per cent of the class. This was in line with proportions elsewhere; the odd school admitted more women, some fewer.

Most universities get around the shortage of women in their classes by citing the relatively small number applying. Although there is some truth in this, many women do not apply either because they are actively discouraged from doing so, or because of what they have heard about the experiences of women medical students.

If a woman is able to transcend the prejudice of her family, her community and her medical school admissions committee and actually makes it into medical school, she must then contend with the attitudes of her teachers and classmates. Admissions committees erroneously assume that many female physicians do not practise.[22] The indignities of the admission interview (how many children will she have? when and what sort of person will she marry?) are followed in due course by the indignities of the lecture theatre and the hospital. These can include slides of naked women interposed between pictures of pathology specimens by the lecturer as a "joke," inadequate changing facilities, and a great deal of condescension and discrimination by male members of her class.[23]

Sometimes the oppression of women in medical school is directed specifically towards their sexuality. The woman is stereotyped as either too attractive to be a physician or, contrarily, as a "horse-faced, flat-chested female in supphose who sublimates her sex starvation in a passionate embrace of *The New England Journal of Medicine*."[24]

Not all nations have made it as difficult as Canada and the United States for a woman who wants to be a physician. Women have outnumbered men in Eastern European medical schools for a long time. The trend in North America, at long last, seems to be to increase significantly the proportion of new physicians who are women; few would suggest that this is not an improvement. The indignities that women continue to experience may be, as Howard Spiro, a gastroenterologist at Yale University Medical School, has suggested, a "cultural lag" that will pass in time.[25] In the last few years there have been such hopeful signs as the willingness of medical students, men included, to confront faculty members who act in a sexist manner in class towards women students or patients.

Showing the way: The Flexner report

Medical school has not always been the preserve of the privileged; gaining admission was not always so difficult. Around the turn of the century, for example, "proprietary" medical schools flourished, in business principally to earn a profit and advertising shamelessly for students (one offering a free trip to Europe for anyone who completed three years of its programme). Much of the momentum for today's admissions policies comes from a report, *Medical Education in the United States and Canada*, that was written three-quarters of a century ago in response to this situation.[26] The report, produced

20 One of the major obstacles to the admission of women seems to have been the problem of having mixed facilities: university authorities were particularly concerned about the prospect of men and women dissecting cadavers side by side.

21 W. Osler, "Presidential address to the Canadian Medical Association, Chatham, Ont., 1885," *Canadian Medical and Surgical Journal* 14 (1885): 129–55.

22 C. Nadelson, M.T. Notman, "The woman physician," *Journal of Medical Education* 47 (1972): 176–83.

23 M.C. Howell, op.cit.

24 E. Ramey, "An interview with Dr. Estelle Ramey," *Perspectives in Biology and Medicine* 14 (1971): 424–31.

25 H.M. Spiro, "Visceral Viewpoints: Myths and Mirths – Women in Medicine", *New England Journal of Medicine* 292 (1975): 354–56.

26 A. Flexner, *Medical Education in the United States and Canada* (Boston: D.B. Updike, The Merrymount Press, 1910).

by Abraham Flexner under the sponsorship of the Carnegie Foundation, and based on Flexner's visits to assess the standards of education at every medical school in the two countries, is generally regarded as one of the most important milestones in the development of North American medical education.

Before the Flexner report, medical education standards had been uneven at best and Flexner is usually given credit for raising them. The curricula in the proprietary schools were often rather informal. As medical knowledge expanded and physicians were put in the position, for the first time, of being able to do something of therapeutic benefit for their patients, it became a matter of some concern that they know what they were doing.[27] After publication of the report, many medical schools closed their doors. Some were schools sponsored by universities that lacked, in Flexner's view, the resources to support them.[28] Others were the "proprietary" medical schools (although it should be noted that a trend to close proprietary schools was already underway when Flexner wrote his report).

Using the Johns Hopkins Medical School as a model, Flexner determined that all students should have a solid foundation of basic scientific knowledge (not the same thing as clinical competence).[29] From a largely functional programme that was supposed to teach students how to treat the sick (and no more), Flexner pushed for a programme that "laid the scientific foundations for medical practice," an approach that has prevailed to this day and has legitimized the growth of an elite medicine and a medical elite.

What was really at stake in Flexner's day was the role of physicians in society. At that time there was no consistent relationship between universities and medical schools and medical practice in the United States. In particular, the apprenticeship system that had characterized the early development of American medicine was in deadly competition with the medical schools, and had been for over a century. Pennsylvania, Harvard, and Yale considered the physicians they trained superior to the products of the traditional educational model, and wanted their "boys" to gain the recognition they deserved. This was not easily arranged, however, because their practice of medicine was not substantially different from anyone else's. Rosemary Stevens, author of *American Medicine and the Public Interest*, writes:

> Attempted distinctions between one doctor and another had to be moulded out of the educational backgrounds instead of functional differences – that is, between those trained wholly by domestic apprenticeship and the small but influential group of practitioners who, by the outbreak of the revolutionary war, were receiving some kind of university education.[30]

This situation persisted despite the best endeavours of two organizations, the American Medical Association and the Association of American Medical Colleges, set up to put a professional autocracy in a position of "leadership" in American medicine.

The proprietary medical schools were an outgrowth of the apprenticeship system and, as Stevens observes, filled an important social role, at least in the nineteenth century, by providing medical care to groups, such as pioneers, who would otherwise have had none.[31] In spite of their contribution, the ever-increasing numbers of proprietary school graduates were seen by the university-trained physicians as a threat and, certainly, as an impediment to those doctors ever obtaining the status in society they desired. Nor were they likely to acquire this status when their professional title was shared with others whom they regarded as "Charlatans" and, with some justification, as vestiges of the feudal era.

Putting them in historical context, proprietary schools represented a stage in American development when capital was more dispersed and free enterprise more free. The movement from apprenticeship to proprietary to university medical education was similar to processes occurring elsewhere in society: the shift, for instance, from the slave-based economy of the south and the relative free enterprise of the north (hence apprenticeship and proprietary schools) to monopoly capital (hence Big Medicine, hospital-based, with a national elite). Flexner's report was written nearly half a century after the landowner class had been routed in the Civil War by the capitalists from the north. Monopoly capital was coming into its own, as Flexner (who worked for the Rockefeller Foundation as well as for the Carnegie) knew as well as anyone. Indeed, it was extravagant funding by the big foundations that allowed the established medical schools, over the thirty years following the report, to become the powers they now are in American medicine.[32]

The report itself, though purportedly offering a disinterested evaluation of the quality of the facilities and educational programmes of the various medical schools, was full of social commentary, particularly in the introduction by Henry S. Pritchett, President of the Carnegie Foundation:

> The existence of many of these unnecessary and inadequate schools has been defended by the argument that a poor medical school is justified in the interest of a poor boy. It is clear that the poor boy has no right to go into any profession for which he is not willing to obtain proper preparation. . . . Progress for the future would

27 It was not until this century that the physician-patient encounter stood a better than even chance of benefitting the patient.

28 R, Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971), 66–70.

29 Ibid,, 67.

30 Ibid., 15.

31 Ibid., 25.

32 Ibid., 69–70.

> seem to require a very much smaller number of medical schools, better equipped and better conducted than our schools as a rule now are; and the needs of the public would require that we have fewer physicians graduated each year, but that these should be better educated and better trained.[33]

Which interests of the public, we may ask, would be better served by having fewer physicians? Especially when, today, there is a shortage of medical practitioners of any quality for many communities.[34] But even if shortages did not exist, is it possible to imagine there being too many physicians? Pritchett apparently thought so:

> In a society consituted as are our modern states, the interests of the social order will be served best when the number of men entering a given profession reaches and does not exceed a certain ratio. For example, in law and medicine, one sees best in a small village the situation created by the over-production of inadequately trained men. In a town of two thousand people, one will find in most states from five to eight physicians where two well-trained men could do the work efficiently and make a competent livelihood. When, however, six or eight physicians seek to gain a living in a town which can support only two, the whole plane of professional conduct is lowered in the struggle which ensues, each man becomes intent upon his own practice, public health and sanitation are neglected, and the ideals and standards of the profession tend to demoralization.[35]

Some of Flexner's own arguments lacked substance. For example, he cited towns of two hundred or fewer inhabitants with two or more physicians as evidence that there were too many practitioners,[36] forgetting or ignoring the possibility that such medical practices attract patients from rural areas. He concluded: "The country needs fewer and better doctors . . . [and] the way to get them better is to produce fewer."[37]

While much of what Flexner said about medical schools was true, often devastatingly so, an important consequence of his report was that fewer physicians went into practice in the United States. Clearly, there were enough physicians to serve the well-to-do, as there would always be. But the cutback in the number of physicians graduating each year led to a much-heralded physician shortage, one that is still being combatted, mostly through the importation of medical school graduates from overseas. If all of Flexner's recommendations had been followed and even more medical schools closed, the situation would now be even worse. He contended that a state or province without a medical school could always attract physicians from somewhere else.[38] If, for instance, Dalhousie University in Halifax had followed his advice[39] and closed what was, until recently, the only medical school in Atlantic Canada, there almost certainly would have been grave shortages of practitioners because, even today, most medical schools favour native sons. They do this on the reasonable assumption that if those schools do not provide doctors to their native provinces or states, no one else is going to do so.

While there were very good reasons for closing some of the atrocious medical schools that existed at the turn of the century, certain people benefited from the closures. The business community stood to benefit in at least three ways. First, it could be assured of a reasonable standard of medical care (decreasing the number of practitioners would not limit the access of the well-to-do). Secondly, businessmen's children pursuing medical careers were to be guaranteed a higher social standing. Finally, the concentration of medical education in hospitals was, in a number of ways, good for business.[40]

On the other hand, while the social and economic status of the medical profession was elevated, the "poor boy" was deprived of his chance to become a physician. "A mass of unprepared youth" was no longer "drawn out of industrial occupations into the study of medicine."[41] The quality of medical care may have improved but its accessibility was reduced.[42] Flexner, who was at least as concerned with limiting the number of physicians as he was with improving care, was apparently not bothered by such considerations.

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33 H.S. Pritchett, "Introduction" to A. Flexner, op.cit., xi.
34 R. Stevens, op.cit., 364–65.
35 H.S. Pritchett, op.cit., xiv (emphasis added).
36 A. Flexner, op.cit., 15–17.
37 Ibid., 17.
38 Ibid., 15.
39 Ibid., 150.
40 This will be discussed in chapter six.
41 Ibid., 21.
42 R. Stevens, 0p.cit., 71–73.