sional service. Medicine is a money-making career in America—that is, one might say more engagingly, medical skills are amply financially rewarding. The idealism, which still holds poetic sway over the medical profession in Britain and among their patients, is largely absent as a motivating force for their American counterparts. The medical profession in the U.S. is a major artery to social status and material ease, a guarantee to respectability for arrivals from whatever income bracket.

The emigration of doctors from Britain may, as some observers argue, threaten a shortage of doctors, but the real fragility of the hospital service arises from the fact that Britain, like the United States, already depends on foreign doctors for the working margin of hospital junior staff. Medical school graduates from the colonies and the Commonwealth have traditionally come to Britain for postgraduate training. Now more than 40 percent of junior staff in British hospitals are foreign-trained, and many hospitals, particularly those outside the major urban centers, literally depend on these immigrants to staff important services. The underdeveloped countries now are offering more opportunities for postgraduate training to more doctors, and finding ways to keep them.

There is little evidence that doctors —who are, after all, middle-class professionals—are alienated from the Welfare State. The concept of a National Health Service—medical care according to need—appears to be generally accepted by doctors, particularly by those who have entered the profession since World War II. The current protests of the junior staff might fairly be said to have arisen because things haven't changed enough. Under the old system the doctor worked very hard, deferred marriage and the enjoyment of family life until early middle age, but could then expect to achieve a status and income that repaid him for his efforts and patience. Now, it is argued, the arduous journeyman years haven't changed but the rewards have diminished. Because medical services are more fairly distributed, patient loads are heavier and facilities often are inadequate or overtaxed. Medicine has become less attractive relative to other pursuits. The scientist and university professor have forged ahead in status. The advertising man and business executive, with their expense accounts and perquisites, fare better in a system where taxes on regular income are extremely high.

At a time when a main topic of political discussion in Britain is the prospect of a statutory wage and income policy, it should be noted that doctors under the NHS have been living under something very much like an income policy since the establishment of the NHS after the war. The pay freeze, which triggered the junior hospital doctors' summer discontent, only serves to emphasize this.

One way a doctor can express himself, of course, is to emigrate. The loss of trained medical manpower is a serious matter for any country, particularly for a country like Britain where the state heavily subsidizes the education of doctors. The emigration of a doctor may not, in fact, in any serious scheme of social accounting, be a more serious national loss than the emigration of a nuclear physicist, a molecular biologist, an aircraft engineer, or an electronics technician, but the impact on the public is probably greater.

In dealing with the matter of emigration, Health Minister Robinson, in his speech at Birmingham, estimated that the total cost of training a doctor in Britain today is £10,000 ($28,000), of which the cost to the government is some £7500. In press reports of the speech, Robinson was portrayed as branding emigration by doctors a "cynical and selfish act." But, as this excerpt from the text shows, he trod quite carefully.

> Now I want to be careful here not to push my point too far. No one would argue that because a young man had received his schooling under the state educational system—also at the expense of the taxpayer and ratepayer—he was under a special obligation to stay and work permanently in Britain on that account. But primary and secondary education are available to all whereas medical education emphatically is not. It is limited in volume by the number and size of our medical

## Medical School—Harvard Panel Seeks Changes

With a few exceptions—notably among new medical schools—innovation in medical education has been considerably more talked about than tried. Most established schools have conformed to a rigid pattern in which all students, whatever their previous training, have been forced to absorb an increasingly heavy amount of prescribed factual knowledge. In the usual pattern, basic science is taught during the first 2 years and clinical experience is acquired subsequently; deviations from the pattern, and elective courses, have generally been held to a minimum.

Recently a committee* of faculty members from Harvard Medical School called for a flexible curriculum that takes into account differences among students in both background and aspiration. Their report, now being debated by the medical faculty, seeks to change the nature of the medical school: they want to create "an atmosphere of a graduate school rather than of a trade school" by reducing the "amount of factual information and memorizing pressed on the students" and encouraging instead independent interests, thinking, and scholarship.

At the same time they hope to counter the tendency of research-oriented medical schools to produce researchers rather than physicians. A major purpose of the new program, in fact, would be to "maintain the motivation of most beginning students to help suffering humanity by introducing them early in their training to patients." The proposed curriculum includes a central required dose of biological, behavioral, and clinical sciences, but these subjects would be spread throughout the 4-year period and integrated in such a way as to become mutually reinforcing. Electives would play a far greater role, beginning in the first year and in some cases constituting an entire trimestral program. The concept of a free-wheeling medical education is in itself significant; its backers clearly hope that the uses of freedom—if the program or some variant of it is adopted—will be still more significant.—E.L.

* The Committee was headed by Alexander Leaf, chief of medicine services at the Massachusetts General Hospital. Other members were Adelbert Ames III, David G. Freiman, Howard W. Hiatt, Manfred L. Karnovsky, Samuel L. Katz, John C. Nemiah, and Victor W. Sidel. A limited number of copies of the report are available from the Office of the Dean, Harvard Medical School, 400 Washington Street, Boston, Massachusetts.