Ruth L. Kirschstein
(New Engl J Med 1996; 334: 982)

The role of women in our society has been changing rapidly over the past two or three decades. Nowhere is this trend more striking than in medicine. Women constitute over 40 percent of the student body in medical schools today, in contrast to less than 10 percent in the late 1960s and early 1970s. What happens to these women after they graduate, however, is less well understood. Do they continue to be active? Do they work fulltime or part-time? Are they rewarded appropriately, on the basis of their educational level, postdoctoral training, years of experience, and abilities? Do they earn less than male physicians engaged in comparable activities? Does it matter whether they go into practice or remain in academia? (...)

In this issue of the Journal, Baker reports that the difference in the earnings of young male and female physicians (those under the age of 45, with two to nine years of practice experience) is fully explained by the number of hours worked. In addition, the gap in earnings between men and women entering practice narrowed significantly between 1986 and 1990. This is the good news. However, there are still differences between the earnings of men and women in certain specialties. Furthermore, the proportion of women in residency training in specialties such as surgery remains extremely low, although a higher proportion of women than of men enter primary care fields. As Baker notes, the choice of a specialty depends on a variety of considerations that may be different for women physicians, who often take family responsibilities and social roles into account, than for men. (...)

As the United States enters the 21 century, it is imperative that women physicians, who appear to have achieved equity in earnings in medical-practice settings, also achieve greater prominence in academic and organized medicine. When that ocours, the large number of female medical students will see that women not only can excel in practice but also can be leaders in medical schools, research institutions, and professional organizations. Only then will the news be entirely good.

Jerome P. Kassirer
(New Eng J Med 1996; 335:507)

Ten years ago several educators proposed that the teaching of clinical medicine should shift from inside to outside the hospital. They observed that there was a discrepancy between the kinds of patients seen on the inpatient services and those seen in physicians offices, and suggested that resident training should be better tailorest to match the requirements of clinical practice. For many years few heeded their call for such a dramatic change in residency training. (...)

At present, a large fraction of resident training in all but a few specialties is still focused on hospitalized patients.

Today we are confronted with a new, rather urgent educational dilemma. The inpatient service has become an even more anachronistic site for learning clinical medicine, and at the same time the impediments to shifting training away from hospitalized patients are even greater. As the cost of care has increased faster than our willingness to pay for it, hospital stays have shortened, many patients who are admitted stay only long enough to have a cardiac, radiographic, or endoscopic procedure, and most of the important diagnostic problems are solved outside the hospital. (...)

Training at free-standing ambulatory care centers, community health centers, ambulatory care sites of managed-care organizations, and private doctors offices are all being considered.

There has been substantial experience with resident education in some of these remote sites, but not much in others. Family medicine has a well developed ambulatory care teaching program in nearly 450 free-standing family practice centers. Residents spend a minimum of half their total training with ambulatory patients under supervision by staff physicians in these centers and in other ambulatory care facilities.(...)

There are no reliable data on ambulatory teaching in order sites not directly connected with academic medical centers, but the amount appears to be small.

To switch the locale of most clinical teaching, we must solve another formidable problem — name educational credentialing and evaluation. (...)

Understanding the continuation of care from acute illness through a disease chronic phase is fundamental to a physician's education. If we erred in the past, it was in overemphasizing acute care. As more clinical education moves into ambulatory settings, we should take care not to make the inverse mistake. (...)

Is there a serious disfunction between current training and current practice? A group of practioners only a few years out of their training recently reported that felt inadequately trained in practice management and cost effective practice. (...)

Lastly, as we change teaching sites and modify our curricula to keep pace with the rapidly changing health care system, we must be unwavering in our attention to the quality of the educational experience and the benefits of training that accrue to patients. We stand to lose a lot if we lose sight of this goal.

Robin Fox
(J Royal Soc Med 1996;89:301)

If you do a public opinion poll on priorities for medical research, top of the list will be cures— for cancer, heart disease, blindness. But ask patients and their relatives and you hear a different story. Many want research on better ways to live with ill-health, and some will declare that clinical trials based on a narrow medical model of disease have neglected their prime concerns. (...)

Researchers have so far been reluctant to involve consumers in this way; and, even when consumers have been consulted on the design and end-points of trials, there have been barriers of language and culture. Some consumer representatives even express the fear that, if they lend a hand, they may be accused of joining 'the enemy'. Researchers the enemy: has it come to that? (...)

Perhaps one reason why the term 'evidence-based medicine' generates strong antibodies is that the evidence we possess is so incomplete; and a narrow medical rationalism may be one reason for the drift from conventional medicine. The latest information on this phenomenon comes from South Australia, where a population survey showed that 20% of adults had visited an alternative practitioner in the past year — most commonly a chiropractor. The typical user was not chronically ill but an optimistic young person who took regular exercice. The economic implications are not trivial: the calculated costs of alternative medicines in Australia were nearly double those of all prescribed pharmaceutical drugs. (...)

One thing is clear: when assessing treatments, whether conventional or alternative, clinician-scientists need to broaden their perspectives.The most important ingredient in alternative medicine, severely rationed in conventional practice, may even be time — the time to listen and connect. When a new community hospital was being built last year in a state of New England, the planners declared that the examination rooms should have no chairs for the doctors: chairs might encourage them to sit down, chat, and thus become less cost-effective. The planners, suspect, could not have been more wrong.