is humanly possible, but we will not ask for more resources than we can responsibly manage. Nor will we promise more than we can deliver.

We have had face-to-face dialog with those at risk —the AIDS victims and those representing them— because we need to have them understand, for their own well-being and protection, just what the scientific evidence is. PHS people met with leaders of the National Gay Task Force to solicit their help in transmitting helpful, accurate information to the group at highest risk: homosexual and bisexual men. It was important to do this, and also difficult; to repeat, hardly any issues are more volatile in our society than issues of human sexuality and personal privacy. But issues of morality are not the issues of AIDS. It is important that the gay community, the medical profession, and the Public Health Service be clear about that.

I believe that our staffs were tested on their ability to hold to the scientific issues and not be drawn into other matters for which we have no objective data or over which we have no legal authority. We are learning many things we were never taught in medical school, but most important of all, we are relearning the proper boundaries of our role as public health professionals.

We have met with and still meet with many who oppose our work, who object to the expenditure of public funds to find a cure for AIDS or the relief of its victims. As public servants, we are obligated to receive their grievances and to hear their request for redress of some kind. We cannot slam the door on any public petition. But we are obligated by law and by the ethics of our profession to pursue the scientific basis for this terrible disease and find a cure as quickly as we can. That quest has been, and will remain, the vital center of our policy.

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Excerpted from Dr. Brandt's address to the Annual Roundtable of the U.S. Conference of Local Health Officials, held in Washington, D.C., September 15, 1983.

The GME Quandary: Who Will Pay for the Piper's Lunch?

He who pays the piper calls the tune.—Proverb
There is no such thing as a free lunch.—Common economic wisdom circa 1980

The system of graduate medical education (GME) in the United States is at a critical juncture in its development. The established relationships which have grown up between hospitals, medical schools, payors, and generations of house staff now are being strained.

The stresses come in a variety of forms and from multiple directions. The demand for graduate education continues to increase, not only as graduates of the U.S. medical schools seek training spaces, but also as U.S. citizen graduates of non-U.S. schools and foreign medical graduates compete for available slots. At the same time, the total supply of first year positions is leveling off, or even decreasing somewhat. In a general environment of cost containment and restrictions on hospital inpatient costs, many decisionmakers in inpatient settings are deciding that they will sacrifice a certain number of positions each year. And if this conflict between supply and demand were not in itself suitably complex, the ongoing issue of specialty "maldistribution"—a struggle to find the right balance in GME offerings between the needs of primary care training and those of the more limited specialties and sub-specialties—adds to the problem. In brief, our system of pluralistic, decentralized decisionmaking that has served us so well for the last 40 years is being sorely tested.

In an area so complex, it is dangerous to oversimplify. Yet, two common themes seem to emerge from the proceedings of the Conference on Graduate Medical Education (from which a selection of papers is published elsewhere in this issue). These themes are cost and control.

The system of graduate medical education that has evolved over the last two decades in the United States has been successful in resisting the vesting of control of GME in the hands of any particular interest or organization. Definite and important roles are played by the profession (accreditation), teaching hospitals (sponsors of training programs), insurers (payment), and house staff (services). Yet a central question which is raised and discussed in these conference papers is the degree to which there should be

greater coherence and unified control over our GME enterprise. Should there be a greater degree of planning? Should perceived imbalances between specialty requirements and GME slots be "balanced" by some external entity? If, in a time of shrinking resources, there is a demand for greater coherence in our planning and allocation, which of the interests can be entrusted with the responsibility for carrying out this expanded agenda of planning and coordination? In making such decisions, who, or what interests, will be in the position to call the piper's tune?

The second central problem that appears from these discussions and papers—that of cost—is not unrelated to the issue of control, yet it provides complexity from a different vector. The majority of the costs of graduate medical education today are supported by the insurers and payors of medical care. This indirect method of funding has been one of the factors that has allowed such a degree of decentralized decisionmaking to flourish within the American system. It also has been one of the elements that may have had some untoward influence on the distribution of GME positions by specialty type. The issues of who shall pay the cost of GME, and the implication as to who may assume greater control over the system, are closely intertwined, although separable. It is clear, though, that the system may, in the future, be forced to make a series of conscious funding decisions—hence choices—to support an activity that has heretofore been treated as something of a "free lunch."

From the point noted above, as well as those in the broader set of issues discussed in the conference papers, it is clear that the future of graduate medical education will be strongly influenced by ongoing changes in the health care system. Although many of these changes are directed primarily at the service sector rather than the educational component, they will have both positive and negative consequences for the whole of the graduate medical education system.

The conference discussion has heightened our appreciation of the degree of symbiosis between the delivery of medical services and the process of graduate medical education. It is almost inevitable that the initiatives related to cost containment, the overall increase in the supply of physicians, and the expanding interest and influence of corporate entities will have significant effects on the availability and distribution of graduate medical education opportunities.

Each of these issues has considerable implication for the process of graduate medical education. Of particular importance are the cost containment efforts which have dominated the debate in recent months, and which have prompted a fresh examination of the incentives for supporting graduate medical education. To the extent that these cost-generated examinations lead to greater efficiencies and educational innovation, the service directed austerity measures may well strengthen the GME system. On the other hand, if our response is solely to medical services issues and problems, there is increased potential for unintended effects on graduate medical education. A failure to integrate cost-base changes with the total needs of the graduate medical education system could well generate adverse changes in the quality of medical care, a deterioration of learning opportunities for residents, and a further skewing of our present specialty maldistribution.

As in any time of change and transition, these events present both opportunities and dangers to the medical profession. In the last half century medicine has been unique in its ability to retain almost sole responsibility for the determination of the qualities and attributes that characterize a physician suited for practice. To a large extent the medical profession has been able to maintain its position of influence because of its successful establishment of a balance of responsibility between itself, academia, hospitals, payors, and State and Federal governments. From the scope of the issues raised in this conference, the conclusion is inescapable that if the medical profession is to retain its preeminent role in the determination of the quality and quantity of graduate medical education, these cooperative relationships must be strengthened, and a high degree of communication and planning among all affected parties must be maintained.

If the medical profession does not wish the basic options regarding graduate medical education to be determined by others, it must be aggressive in articulating the needs of GME which are truly in the national interest, and in addressing how GME costs shall be met.

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