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ARA PRESIDENTIAL ADDRESS

A NEW ROLE FOR THE ARA IN GUIDING OUR DESTINY

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It is with considerable pleasure that I address you at the 1987 annual meeting of the American Rheumatism Association. Lois and I have very much enjoyed the opportunity to interact with so many outstanding people in the field during the past five years that I have served as an officer of this organization. What is especially exciting and gratifying for me now is to be part of the *new* American Rheumatism Association. Our organization has evolved dramatically over the past five years. No longer are we a group committed solely to publishing a reasonable subspecialty journal and putting on a good national meeting once a year. We now have the organization firmly in place that will enable us not only to handle these traditional responsibilities but also to identify those issues that will affect our professional destiny and to provide, on behalf of our membership, influential guidance at the national level.

Let me review some of these recent changes which have occurred in the new ARA. First, the critical issues involved in the dissociation of the ARA and the Arthritis Foundation now are resolved and behind us. Second, our executive office has matured nicely since the split with the AF and is now entering a new level of stability. We have a new executive vice president, Mark Andrejeski, just on board, who has the appropriate background, a dynamic approach to management, and some innovative solutions to the remaining issues facing the new ARA. We have a new communications office, which is off to a great start with Lynn Forbes as the director.

Third, the leadership of the ARA is strong and now quite experienced. Provisions have been made for substantial continuity. Our new groups and councils are developing well and functioning effectively.

The officers, meeting as the Executive Group every two or three months for the past year, have worked hard to stabilize the ARA's many developing activities. We are particularly proud of our new membership categories, which provide appropriate recognitions for individuals, particularly those at the fellow level. In addition, we are especially pleased to be able to recognize our first group of Masters of the ARA later this morning. Dr. Steve Malawista has effectively implemented these new levels of recognition. Finally, you will hear at the business meeting about the initiation of four new ARA awards: the Young Investigator Award, the Distinguished Investigator Award, the Distinguished Rheumatologist Award, and the Gold Medal.

The Finance Group, under the able direction of Dr. Jack Stobo, has put the new ARA on a stable financial footing so that we will be able to afford to meet some of the challenges of the future. The Admin-

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istration and Evaluation Group, under the capable leadership of Dr. Paulding Phelps, is off to an excellent start. The Planning Group, under the able guidance of Dr. Ira Goldstein, has just completed its second retreat and now is in a position to provide the intelligent leadership we need as we try to prepare for the long-term changes that will affect rheumatology.

All three councils are prepared to play increasingly important roles in leading the new ARA as we play a more prominent role at the national level. The Research Council has improved our liaison with individuals at the National Institutes of Health. This will be further enhanced when this council's Washington representation is established. The Education Council, in addition to considering a number of new programs which will be of considerable benefit to rheumatologists, has applied to the Accreditation Council of Continuing Medical Education to enable the ARA to provide CME credits for our educational activities. This application is being reviewed by site visitors here this morning. Approval of this program will catalyze the expansion of our efforts to improve the knowledge of nonrheumatologic physicians and other health professionals involved in the care of patients with rheumatic diseases. Following its first retreat, the Committee on Rheumatologic Care, or CORC, is ready to give authoritative representation to our views. CORC is being assisted in this by the American Society of Internal Medicine, with whom we have contracted during the past year. Our efforts to be heard on Capitol Hill have started off nicely, and the assistance of Ms Hope Wittenberg deserves our special recognition.

Indeed, this week, during the time of this annual meeting, many members of the ARA are meeting with members of Congress and their staffs to express our views on two issues central to the welfare of our members. First, we are reemphasizing the important role the NIH plays in supporting the research programs of the nation and how vital it is that Congress improve the funding of all NIH programs, including that for our new institute, the National Institute of Arthritis and Musculoskeletal and Skin Diseases. Secondly, we have emphasized to members of Congress the importance of appropriate payment for cognitive skills. In this regard, rheumatology is very much part of the national Relative Value Study, which we hope will move us toward the achievement of concrete solutions in this area.

Now that we have the organization in place, we must identify the key issues for the future. I have had the good fortune of working closely with the Planning Group on these, and I feel confident that we are anticipating the future as well as it can be done. Recently, however, I have become concerned with future manpower needs in rheumatology, and I believe we need to pay special attention to this issue. All of you are well aware of the predictions of oversupply for most medical specialties, including rheumatology. I feel, however, that the pendulum of manpower supply is now beginning to swing rapidly in the other direction. Using the data now becoming available, I am concerned that we could have a very serious problem of *undersupply* of new rheumatologists by the year 2000 if we don't face the issue now.

What is it that has me concerned? Currently our numbers appear to be very stable, with approximately 400 fellows in rheumatology training at any one time and approximately 175 to 185 completing training in the field each year. Indeed, we are still at somewhat higher levels than those recommended by the Graduate Medical Education National Advisory Committee study. But let me put these data into perspective. Although the number of physicians entering our field each year has declined only 2% since 1979, there is only one other subspecialty of internal medicine which has had a greater reduction of manpower in the same time period. In fact, just as a comparison, the number of physicians completing their training in allergy in the same period of time actually has increased by 54%. Recall, as well, that this drop of 2% occurred while the number of medical school graduates was still going up.

To look ahead now, let me remind you that we are beginning to see a decline in the absolute number of medical students enrolled. This reduction in medical students has occurred for a number of reasons and is expected to accelerate. One of these reasons is the rapid decline in the number of applicants to medical school. During the past twelve years, the total number of applicants has dropped from 42,000 to 29,000 per year. Since the number of applicants has declined more rapidly than has the number of students accepted, the acceptance rate has risen. The inevitable result, if this continues, will be not only a further reduction in number of students admitted, but also a decline in their quality.

Narrowing our focus, we have now begun to see a striking decrease in the number of medical students interested in pursuing careers in internal medicine. This year, the number of US medical graduates entering internal medicine programs is 5% lower than it was last year. More than 40 of the 120 university training programs in internal medicine, including

several outstanding programs, failed by wide margins this year to fill their programs. It is expected that this decline also will accelerate. Thus, the effects of the decline in the number and quality of students entering medical school will be further compounded by a reduction in the fraction of medical students choosing training in internal medicine.

Narrowing our focus still further, we find that the students who do choose internal medicine are more likely to pursue either general medicine or one of the procedure-oriented disciplines. For example, of all residents completing their training in internal medicine in 1975, 75% entered subspecialty training. In 1987, however, only 53% will enter subspecialty training. In addition, of this dwindling group entering subspecialty training, an increasing fraction are pursuing the procedure-oriented disciplines.

The problem can be put into perspective by reviewing the career plans of this year's senior medical students. Of nearly 11,000 senior medical students answering the American Association of Medical Colleges questionnaire this year, only *14* students indicated an interest in pursuing a career in rheumatology. Of those senior students who were undecided, only 27 students, nationwide, identified rheumatology as their first choice. Thus, if we extrapolate to the number of 16,000 seniors nationwide, only *0.4%* of this year's graduating medical classes, or about 60 students nationally, have chosen or are even seriously considering a career in rheumatology. On the average, this amounts to less than one-half of a graduating senior for each medical school in this country this year.

As I see it, such an undersupply would pose some very serious problems for the specialty—considerably more serious than those posed by the previously projected oversupply. Because of our limited accessibility, our patients would be handled by other specialists and primary care physicians. I am convinced that, if this happens, their health problems would not be handled as well as they might be. Not only might the quality of care suffer, but, indeed, we might find ourselves back in the era when no one was sure why you needed a rheumatologist anyway. A decrease in manpower not only would reduce the number of clinical rheumatologists, but also would severely limit the number of clinical investigators working in our field. And, this, in turn, would impede the progress of science in rheumatology at a very exciting time, ultimately doing a great disservice to us and to our patients.

There are several approaches we can take to this potential problem. While you may not agree with my forecast, you may find these proposed solutions worthwhile projects in themselves. Indeed, some of them may help us to deal with other issues which the ARA is facing. For one approach, the first I'll identify, the ARA is taking an active role. The other four, however, are approaches which we are not actively pursuing as an organization, and I believe we should. I hope the Planning Group will add them to their agenda.

First, I believe we do need to correct the *inequities in compensation for cognitive skills.* This approach by our membership should be a broad-based one which would include Congress, the Health Care Financing Administration, and third-party payers of all types. The relatively low rate of compensation for the practice of rheumatology is one of several factors negatively influencing career choice among our students. As you know, the ARA already has begun to work in this area.

Second, I believe we need to expand the specialty of rheumatology to cover some of the peripheral areas which now are largely ignored and sometimes poorly handled. This would include expansion of our activities in nonoperative sports medicine, evaluation and treatment of patients with low back pain, management of patients with bone disease, and the use of certain technical procedures which are appropriate to our specialty. By expanding the field and including these activities as part of our training, I believe we can substantially improve the quality of care if for no other reason than by stimulating the interest of other specialists in these areas. If we take an active interest, ultimately, whether we're delivering the care or others are, the quality will be improved.

Third, we need to enhance the quality and excitement of our training programs. I believe we should reduce the sites for training in rheumatology to those which can provide the most exciting training in the country. This could be accomplished by tightening the accreditation standards and thereby discrediting the weakest programs. More importantly, this will stimulate the weaker programs to become better. The net effect will be a marked increase in quality. We can do this without reducing the number of trainees, because the capacity of our training programs now far exceeds the demand. This will be a controversial approach, but one which I think will be best for the discipline in the final analysis.

Fourth, we need to increase the recruitment of students and house officers to rheumatology. It is of interest that, nationwide, there are approximately 850

to 950 senior medical students each year electing to take rotations in rheumatology. However, less than 8% of students rotating through rheumatology as senior medical students eventually select rheumatology as a career. This is the lowest percentage of all the medical subspecialties. (The others range from 9% to 56%.) Clearly, we have access to a substantial number of students. Now we need to make a special effort to enhance the quality of that experience so that they will have a greater likelihood of pursuing rheumatology as a career.

Finally, I believe the ARA would do well to have its executive offices in the Washington, DC area. Much of what we are doing now would be easier and more effective if we made this move. We should also give some thought to having our annual meeting in the Washington, DC area more frequently than we have in the past. Perhaps every other year or every third year would make sense. We have, this week, begun to develop a better relationship with members of Congress. They now know who we are, and they are interested in our views. We have a real opportunity to have an impact, and we should grab the brass ring while we have the opportunity.

I appreciate your attention to my comments this morning. I hope I have provided some food for thought. I would like particularly to express my appreciation to the four past Presidents with whom I worked, who were instrumental in designing and implementing the new ARA: Gerry Weissmann, Jim Klinenberg, Eng Tan, and Ted Harris. Finally, let me say, and I speak for both Lois and for myself, that being President at the time of such change in the ARA has been a superb experience for both of us. We deeply appreciate the opportunity to have served the organization over the past five years. Thank you.