In response to profound socioeconomic pressures on medical student education, splendidly catalogued by Albanese et al as “teaching patient shortages, teacher shortages, conflicting systems and financial problems,” a medical student education revolution has begun. Though hardly anyone acknowledges it as a revolution yet, this revolution was predicted in 1999 by Ludmerer,2 who described medical education in the 1990s as “prerevolutionary.” If it is not guided wisely, or even aborted, there is a good chance that these changes will result in a system that is inadequate, inauthentic, or corrupt. The revolution’s challenge to medical student education is, “Are classes, classrooms, medical school faculty, departments, medical schools and buildings, and even patients, necessary?” Its response is, “They may not be.”

After the revolution, a monopoly of commercial medical education Entities will employ stable of top speakers (or actors reading scripts) whose wisdom will be piped electronically to medical students gathered in strip malls, storefronts, and apartments, who in turn will be tested in private learning centers. National standardized curricula will replace laborious school-by-school curricular planning. Clinical teaching will be outsourced to doctors receiving market wages for fitting students into their practices, or to medical centers to pay for doctors’ time.

Entity models already exist as online universities,3 nationally taped professors’ lectures,4 drug-company-sponsored medical education companies (MECs),5,6 Stanley Kaplan courses, private testing centers, and outsourcing of clerkships by Caribbean schools.7 An international, for-profit virtual medical school is being marketed in the third world.8 Maybe a few highly endowed, enterprise transnational universities will survive and obtain a solid share of this Entity-based market.

The Entity will market itself to students as if they were consumers, promote the theme that each student learns differently, and provide a menu of modules tailored to students’ learning styles,1,7,9 akin to sleep-number beds tailored to customers’ sleeping styles. In so doing, it will claim to follow the principles of learner-centered teaching (LCT).10–16

The menu of modules would include downloads of lectures, podcasts, standardized patients (SPs), small groups, team-based learning, problem-based learning, patient-based learning, audience response systems, Jeopardy-style games, online courses and modules, Web sites, books, review books, summaries of review books, test item banks, and God knows what else.1 Most medical school faculty would be replaced by, or reinvented as, educational “techs,” “guides,” or other faculty extenders1 comparable to waitpersons. Wearing aprons, we would greet students with “Hi, I’ll be your server. Would you like your mood disorder curriculum with white or red sauce? Spicy or mild? For here or to go?”

At most medical schools today, lectures in the first two (i.e., “preclinical”) years are taped,1 while attendance shrinks dramatically.1,17–19 For professors who conduct these classes, this phenomenon feels like every student sending regrets to some sort of educational party: “Sorry,
can’t attend, but please send wine and hors d’oeuvres!” Alternatively, absent students are said to “vote with their feet.” At one school with massive faculty “downsizing,” the remaining faculty were asked to prepare and e-mail “teaching modules” to fulfill requirements when no faculty member could attend to teach in person. A colleague described this as “auto-erotic asphyxiation minus the erotic part.”

Also in the preclinical years, many real patients are replaced by standardized or vignette bank ones, lowering each “patient” encounter’s stakes but sacrificing the students’ priceless opportunity to learn about their encounter’s outcome and validate their diagnoses with laboratory studies. Autopsies will continue as rare, quaint vestiges of medicine’s history. Physicians who now wax poetic about learning medicine outside their specialties during their general internships will be dead.

After the revolution is complete, the third medical school year will consist partly of apprenticeships with practicing doctors who, unlike early- and middle-20th-century preceptors, will have scarce time to teach and, consequently, will view teaching as burdensome. Alternatively, some who love teaching but lack protected time will try “time-efficient teaching,” akin to one-minute managing or eight-minute doctoring, but many will find this aversive. The Entity will pay market wages or give money to medical centers to offset the cost of teaching time for doctors, for whom there will be no loyalty to a university. Already, most Caribbean and some U.S. medical schools outsource clinical rotations, and many clinical settings are shared by students from multiple schools. These experiences would be supplemented by SP encounters, patient holograms, resuscit-Annies, and other proxies.

Medical students caring for real patients under the supervision of wise physicians and senior residents with sufficient time to teach—the magnificently authentic “gold standard” of medical education—will, because of the emphasis on physician productivity, be viewed as “the old paradigm” and scrapped. Grades will inflate even more as students rely on the Entity for medical education because businesses don’t flunk customers who pay their bills, and because it is unsustainable in a litigious society to flunk a student without documenting continual intensive supervision, feedback, and warning.

In the fourth year, the Entity will outsource students’ education to preceptors and medical centers nationwide so that students can audition for residency. Of course, this has already been the case for the past 30 years. Postrevolution, though, these audition electives will be conducted American Idol-style, often rewarding flash over substance and relying on promises of fame and fortune over learning, exploring, and selecting a suitable match. With students learning at a distance during the first two years, lacking adequate patient-care responsibility in their third years, auditioning during their fourth years, and skipping general internships, their real medical educations will begin in residency.

Legitimizing this, as always, would be credentialing backed by tests, testing companies, and background checks. Testing would be done increasingly through United States Medical Licensing Examination (USMLE) shelf exams or Entity-produced exams. Exams written by faculty members responsive to department curricula will become museum relics. Because the public won’t abide uncredentialed doctors (or other undesirables, like Al-Qaeda members and child molesters) treating them, background checking companies will continue to proliferate.

As knowledge continues to expand exponentially, from millions of times more than Pasteur, Freud, or Flexner knew, to billions of times more than we know, medical textbooks will enlarge enough to cause hernias when lifted and will be read for reference, not pleasure. Their online versions will transport easily, but nobody will read them. Review books will be written by students and residents, titled something like Squash and Crush the Boards and Wards, and students will view these as definitive texts. Engrossing, cohesive, single-authored texts like Boyd’s Text-Book of Pathology will, like faculty-authored examinations, become museum pieces. Academic free speech (i.e., tenure) will disappear because, although businesses don’t flunk customers, they do fire employees who challenge the boss’s views.

With increasing frequency, medical students will view their staggering private and public school tuition costs as mortgage-like investments for which the goal is professional credentials, with students being treated as consumers or voters. In the near-future economy, such tuition costs will be unsustainable, so medical schools will morph into Entities and charge what the market will bear.

Simultaneously, with increasing frequency, doctors, medical students, and the public will view medicine more as a business than a learned, altruistic calling—a profession. The classic doctor–patient relationship is transforming into a provider–consumer–payer triangle that diminishes rather than enhances the original relationship. Hospitalism further reduces continuity of care. Using the food-server simile again, the provider will act more like a waitperson asking, “Would you like us to treat your depression with white or red sauce? Spicy or mild? Cooked or cold? Will you take your treatment here or to go?” Similarly, the student–teacher relationship will be reframed as a learner–guide relationship, with learners directing their curricula and choosing their textbooks, lessons, and—eventually—their guides. In turn, guides’ (formerly teachers’) tasks will be to point out the locations of the book Web sites, cafeterias, national curricula, and parking lots.

Since the 1980s, there has been progressively less government support of medical schools. Despite a commendable recent movement to develop and reward good medical teachers’ careers, business-oriented administrators have been progressively more likely to view faculty—especially physicians—as too costly. Faculty are now expected to earn their keep through productivity in patient care, drug studies, or grant receipt. Sadly, if these trends progress unchecked, physicians wanting to make medical student education the mainstay of their careers (and there are many of us) will choose other work.

Although the Association of American Medical Colleges (AAMC) and Institute of Medicine (IOM) recently took strong
stances about limiting industry influence on medical education, it remains to be seen how many schools will comply and enforce the guidelines. And in the current economy, nobody advocates for—let alone receives—government support for medical education. Meanwhile, medical school administrators redirect tuition money toward research start-ups and “learning centers,” oblivious to the fact that the university itself is the quintessential learning center.

Causes of the Revolution, and Suggestions for What to Do About It

The engine behind this medical student education revolution is the same unregulated free—and supposedly rational—market that profits from and interferes with the doctor–patient relationship, wouldn’t insure patients with preexisting illnesses, won’t reimburse physicians for bedside and classroom teaching, disguises marketing as “continuing medical education,” tolerates 18,000 of 45,000,000 medically uninsured people dying annually, and contributes to 62% of personal bankruptcies. It prevents Medicare Part D and state governments from negotiating drug costs, markets gabapentin and olanzapine for everything, withholds negative studies, sponsors journal articles rife with industry bias, and ghostwrites sponsored presentations. It labels us as providers, not teachers—let alone teachers of the highest caliber—just making money.

Fortunately, neither full-blown Entities, the revolutionary platforms that Ludmerer predicted, nor Albanese and colleagues’ apocalypse, have fully materialized, although they are well under way in many schools. We have held the line largely because academic medical organizations like the AAMC, the Liaison Committee on Medical Education (LCME), the Institute on Medicine as a Profession, and our medical colleges, using data and commentary from researchers and critics, fulfill our obligation to regulate medical education. Of course, because of lapses, we keep legislators and the press keenly interested. Albanese et al write, “It is essential that a national dialogue begin about how we are going to address these problems. . . . We need creative solutions.”

Fortunately, in 1999 and 2004, Ludmerer anticipated these problems and advanced a rich framework for solving them. He emphasized medical education’s values, purposes, and missions and the will, courage, and leadership required to champion these:

- Our leaders must remember that institutional survival and financial success are meaningless if the core mission and values are not preserved. . . . True leaders are generally notable for their convictions, not their charisma. They ask how their organization or institution can make a difference; champion and exemplify worthy values and purposes, and articulate a mission or cause beyond just making money.

- Using the experiences of my colleagues and myself as unwilling examples in this revolution, I will advance similar recommendations and make new ones.

- Hopefully, the intensive dialogue suggested by Albanese et al will eventuate in an IOM, Macy, Carnegie, or Pew-type report addressing, once and for all, our core values and need for self-regulation. Specifically, we should focus on these themes: academic versus commercial values; authenticity versus simulation; adopting LCT without misusing it; striving for a gold standard curriculum characterized by vertical integration, patient-centered teaching, humanism, and professionalism; and reexamining the shortages of teaching patients and teaching faculty. We must take the high ground, in the following ways.

Give priority to academic rather than business values

Because medicine and medical education are professions, not businesses, practices that are best for teaching, research, and patient care should trump practices that are most efficient or profitable. An example of misguided efficiency would be an official national curriculum ostensibly designed to save faculties from creating or revising their curricula. This would negate each department’s and faculty member’s right and obligation to present and collaborate on their original themes, conceptualizations, data, and discoveries and would result in global “McMedical schools.”

The following example, relayed to me by one of my colleagues, illustrates a “money trumps education” position in a university where the revolution is occurring. With an insufficient endowment accentuated by a recession, a university—whose president and CEO, an invasive cardiologist who consulted for multiple drug and stent companies—started a school of pharmacy to dramatically increase tuition revenue and industry funding. Simultaneously, the CEO asserted that the medical school’s physicians—including many of its finest teachers—should devote virtually all their time to earning clinical income, doing drug studies, or winning government grants rather than protecting critical time for teaching or even doing unfunded educational research, the latter surely being the devil’s work! The chair of its most educationally devoted clinical department retired, its remaining residencies were at risk of closing, most of its clerkships became essentially outsourced, many top-notch clinical educators left, and the typical preclinical student examined a total of seven patients during two years. Its USMLE Step 2, Clinical Skills and clinical shelf exam scores were subpar. To resolve the problem of inadequate clinical relevance (inadequate vertical integration) of “preclinical” classes, the curriculum committee directed basic scientists to produce clinical vignettes for small-group discussions.

Too often, funds allocated for medical education are diverted elsewhere. Much of the funding for medical education is already available, as tuition, endowment, and—for public schools—government appropriation. Decisions made primarily or exclusively for financial gain threaten the core missions, values, and very survival of universities.
Medical schools, not MECs, should teach medical students

Medical schools, not drug or companies or MECs, should educate students and residents.4,5,46 Medical students are extensively exposed to information from drug companies that favors the sponsor’s product.4,5,46 Doctors and students tend to deny, wrongly, that this information could influence their prescribing.46 Consequently, modules or vignettes authored by drug companies or MECs should be used minimally or, preferably, forbidden.

The LCME should require each medical school to have a policy addressing drug company—physician and drug company—student relationships that includes the essentials (e.g., no gifts, no ghostwritten presentations) of the AAMC’s 2008 report49 or the IOM’s 2009 report,50 and site visitors should verify compliance. Moreover, schools should require faculty to disclose their commercial interests to students, just as continuing medical education providers are required to do.

Value authentic education over simulation

All else being equal, education characterized by authenticity, altruism and direct human interaction should trump inauthentic, commercial, virtual, artificial, distant, or simulated education. As Albanese et al write, “Good quality, well-organized and appropriately supervised clinical apprentice experiences have been considered the gold standard in medical education,”13 and as Issenberg et al state, “Though technology never tires, it has not been proven superior to other educational delivery methods and a recent review of the effectiveness of simulations was disappointing in its relatively equivocal findings.”50

Although simulation is precious when students practice risky procedures (e.g., chest tube insertion) so they can err without harming patients, and is central in the National Board of Medical Examiners’ clinical skills exam, it has multiple flaws, especially regarding face and concurrent validity.50–52 A humble psychiatric experience of mine offers an example of the validity problem. One of our SPs imitates hyperactive manics so well that when clerks observe a tape of me interviewing him, virtually all of them correctly diagnose mania. But they have not “seen” a manic patient, as the LCME’s ED-2 prefers. In fact, I have miseducated them because, to capture my entire interview on tape without the SP leaving the room, the script requires him to relentlessly try to leave, but whenever I say, “Mr. Jones, please take your seat again,” he must sit. A hyperactive, real Mr. Jones wouldn’t sit. Manics—like other people—have no scripts. And my students will never know how Mr. Jones responded to treatment because he doesn’t exist!

There are other validity problems in psychiatry simulations that likely apply to other specialties, including (1) SPs don’t bring to the examination the memories and experiences of a lifetime, so questions straying beyond the script may yield irrelevant answers, and (2) it is difficult to empathize with someone pretending to be sick.51,52 A student interviewing a “depressed, suicidal” SP could best empathize by saying, “It must be so difficult for you to play a person on the verge of killing himself.”

Because of this validity problem, simulation is not an acceptable way to fill gaps arising from the LCME’s 44 ED-2 preference that students have a broad variety of exposures to actual patients. In the vertically integrated, patient-centered curriculum I discuss below, students will have ample supervised exposure—live and videotaped, in clerkships and classes—to an acceptable breadth of patients across all four years.

Furthermore, new medical schools (and even old ones) should consider whether they really need simulation centers. If not, to fill the subsequent simulation void, we could screen the Seinfeld episode in which Kramer becomes an SP.

Study, wisely incorporate, and beware the misuses of LCT

LCT1,7–16 is an important, logical, and persuasive educational philosophy and methodology. It is well developed and demonstrably effective in elementary and college education7,8,12,13,14 and has gained recent attention in medical student education.9–11,14,15 Its central theme is that what learners (i.e., students) learn trumps what teachers teach. It posits that we learn and retain best when confronted with challenging, “real life” problems that require us think about and construct theories, express these theories to others, and collaborate about causes and solutions.14 LCT literature describes this learning as experiential, authentic, holistic, challenging, reflective, constructivist, expressive, collaborative, and democratic.14 For example, I am optimally learning about LCT by trying to summarize it or knowingly apply its principles when I teach. LCT also includes the idea that each person has a unique learning style and preferences, which can be clarified by a learning style assessment instrument.7,8

Regardless of their familiarity with LCT, good medical teachers—including good lecturers—already employ LCT features, such as (1) preparing courses by considering what the students should learn and apply, and what they would be most responsive to, rather than what the teacher knows, (2) interacting extensively with the students, and having them interact with each other, and (3) soliciting extensive postcourse student feedback, and using it to improve subsequent courses.11 Most patient-related clerkship activities qualify as LCT. Because of LCT’s success in elementary and college education16 and its face validity, we should incorporate it more in medical student education.

However, our ability and willingness to incorporate it is limited by the sparseness of the medical student education LCT literature. In fact, there are no textbooks on the topic, no rigorous head-to-head comparisons of it with traditional teaching, and no actual or visionary scenarios of a fully developed LCT curriculum.9–11,14,15

The lack of actual or visionary scenarios of a fully developed LCT curriculum is troubling because some LCT proponents predict12—without providing the scenario—that the teacher role will eventually disappear, and teachers will reinvent themselves as or be replaced by “guides.” Then, avuncular wise persons wearing tweed jackets or long white lab coats bearing their embroidered names will appear only in wax museums or as caricatures in old movies.

Another troubling situation is that learning style assessment and learner preference1,8 are becoming the signature feature of curricula marketed by Entities as LCT, leading students to act like customers and causing faculty members to be embarrassed, resentful, and less engaged in teaching, as in the following three vignettes.
1. A medical student advocated for her school’s “LCT” strategy because it perfectly linked her avocation with her future profession. Her preferred study strategy was listening to recorded lectures while practicing her juggling. How this facilitated her becoming a critical thinker or better doctor was less clear.

2. Another student exclaimed, “For my $40,000 a year, I should be able to learn in my most convenient way,” which was to skip class and listen to recordings from the class. Would his own convenience also be his main patient-care priority?

3. After consenting to their classes being taped, faculty members at multiple schools responded dramatically to the subsequent sudden massive drops in attendance and began to question their future in medical school teaching.

Therefore, just as for any other curricular reform, LCT must be well orchestrated, with stakeholder endorsement.63,64

Ensure acceptable preclinical class attendance without requiring it

In college and medical school, attendance is a complex, multifactorial variable that needs unique handling in every school and course. Attending patient-care activities is mandatory and, for obvious reasons, is rarely a problem. Attendance in lectures without required attendance may be influenced as much by student motivation as by teaching quality.65

There is no persuasive evidence that mandatory lecture attendance yields higher class achievement.65 Requiring attendance is insufferable if lectures aren’t top-notch. Yet teachers are hard-wired to feel rewarded by good attendance and disappointed if attendance is poor. As a compromise, teachers should try to bring attendance to whatever is—for them—a critical mass. This includes unique, high-quality class experiences, giving quizzes, and awarding attendance bonus points as in a token economy.

Provide top-notch, authentic, patient-centered medical education

Perhaps the most important recommendation is that medical schools must fund outstanding, authentic, patient-centered curricula. The most engaging and memorable system I can imagine would have the following characteristics: From the school’s first week, the curriculum would (1) be vertically integrated (clinical relevance of what is taught and learned is critical) and humanistic (focusing on patients and their experiences), including preclinical class discussions of recorded or even live patients, and routine supervised live patient experiences, all of which would fulfill ED-2.49 requirements, and tests would include vignettes about real patients, (2) be biopsychosocially oriented,30 addressing multiple dimensions of the patient ranging from the cell to the person to the biosphere, (3) provide four years of exposure to physician role models of professionalism,29 and (4) address all six Accreditation Council for Graduate Medical Education competencies (i.e., facilitate students’ becoming good doctors), so by the third year students can assume meaningful patient-care roles.

Those championing vertical integration would include a critical mass of physicians who love to plan and teach courses and collaborate with basic scientists. These physicians would be core consultants, teachers, or directors of preclinical courses, and would address the clinical relevance of basic concepts. Most medical schools have ample numbers of doctors qualified for this but must protect their time by paying for it. Some schools have persuasively demonstrated strong commitment to protecting physician and basic science educators’ teaching time by properly allocating tuition and state education funds directly to the teachers’ departments for specific, defined, educationally related activities like directing a course, facilitating a small group, or interviewing medical school applicants (unpublished data available from Steven A. Lieberman, MD, University of Texas Medical Branch, Galveston, Texas).

Maximize third- and fourth-year students’ patient-care responsibilities

Albanese et al correctly assert that third-year students don’t have enough patient-care responsibility. They attribute this to a “teacher shortage” and “teaching patient shortage” exacerbated by three factors: clerks being pulled from clinical services for classes, third-party payers not letting students chart meaningfully, and residents competing with students for patients. Also, the preclinical curriculum is excessively knowledge centered.

The following would help solve these problems: (1) optimally educating students in the preclinical years so they could be more responsible for patient care in the third year and could work almost continuously with the clinical team without being pulled for classes on subjects they learned previously, (2) letting clerks draft patients’ chart entries, with supervisors’ “edits” and approvals, preferably in the student’s presence, and (3) assigning well-trained students to selected preceptors or departments without residents. The final item could dramatically address the perceived teaching patient shortage and teacher shortage because any person could be a teaching patient if the clinical unit’s culture supports well-supervised student participation in patient care with informed patient consent, and if patients are properly treated by skillful physicians who love teaching. Fourth-year advisors should strongly urge advisees to develop patient-care skills in electives outside their specialties, rather than spending a year auditioning.

Keep tenure

To combat the Entity-driven scenario in which faculty members become employees who must toe the company line, universities should support Clawson’s28 stance about tenure:

Despite the 30-year trend toward privatization and a pseudomarket environment within . . . universities that marginalize the tenure system, tenure must be maintained to promote the long term development of new ideas; challenge students’ thinking; pursue long term research agendas, and challenge conventional wisdom.

Share responsibility for funding medical education

Although the funding of medical education by society in general is—to quote President Obama in another context—“above my pay grade,” I agree with Ludmerer2 that the “financing of medical education and research should be a shared responsibility of society because these activities benefit everyone” and should include “a federal trust fund for the support of academic health centers, increased use of general tax revenues, and the development of an all
payer system of financing in which education would be supported by a tax on all health insurance premiums."

Rejecting the Revolution
Using the principles, values, and realistic, time-tested, and not profoundly expensive measures I articulated above, and exerts academic medicine’s leadership with society’s support,2,9 we can and will preserve an educational gold standard1 that delivers the value of medical education’s cost to future students. We could do it without resorting, wholesale, to commercialization, simulation, proxy, and standardization, which would lower medical education’s value below what students and society pay for it.

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On Courage

I recently found myself at the Harvard Art Museum with a dozen medical residents gathered around a marble statue of the Roman emperor Trajan. An intern had guided us to the statue in response to a reflection question she held in her hand—“Find a work of art that speaks to a transition you are experiencing.” Gazing up at the proud figure in its ceremonial breast plate and military cloak, the intern shared her hopes and fears about her imminent promotion from intern to junior resident. She was anxious about running a team and the increased responsibility she would assume for patient care. Would she find the leadership skills and confidence to do the job? She wished she felt the way the statue looked, and spending a few moments in its presence had provided her inspiration. The group discussed what qualities allow someone to tread into new territories, to engender respect in others. We talked of the importance of comportment and respect in others. We talked of the statues of the Roman emperor Trajan. Much of what we were talking about was a bit about personal qualities important to doctoring—empathy, equanimity, humanism. But just as much, the medical training process requires courage. Physical courage is needed for the long hours, the sleep deprivation, and the exposure to contagion. Moral courage is needed to report a medical error made by a superior or not to laugh when the chief resident refers to your obese patient as a whale. Emotional courage is required to walk into an anatomy lab and peel back the cover on a cadaver, to care for (dare we say love?) a child with cancer who may die, or to attempt an experimental treatment on that same child that may kill her. Courage is required to risk losing relationships with people and passions outside of medicine, to fear being so transformed by the training process that one’s soul might be unrecognizable to oneself at the end of it all, and to still show up for the first day of internship. Courage must be mustered to enter the world of hateful patients, criminals, and addicts. And, of course, we face these challenges not one by one but all at once.

Perhaps we do not speak of courage because this quality is so intrinsic to physicianhood that to name it is to diminish the power and sanctity of what we do. Or maybe talk of courage would call too much attention to the risks associated with our profession. Is courage a word we might allow into our dialogue about medical education, something we might screen for in our admissions processes and/or attempt to teach? Perhaps we should seek out stories of courage to share with our students and each other. What was it like for the first female or African American medical students, for the first AIDS doctors, for the resident who is himself paraplegic or grew up on welfare? We must recognize the times when our own students are fearful but still behave bravely and commend them for just that. Might we speak to our students of the challenges to and examples of our own courage? These instances need not be heroic tales—a simple story of a time we apologized for a mistake or risked negative evaluation to do what we felt was right for a patient or ourselves. Sources of courage to share with our trainees might come from art or literature, from religion or community. And of course there are no greater examples of courage than those that we witness every day in our patients.

Like the cowardly lion who felt his courage only after it was ceremoniously acknowledged by the wizard, we may need to name it in order for our students to own it. Might we make room for courage among our competencies? Elizabeth Gaufberg, MD, MPH

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