

Opinion

BY RICHARD P. MILLS, MD, MPH

How Will We Train the Next Generation?

You may have noticed that I've moved. I'm back in Seattle in private glaucoma practice. Mostly, the decision to return was personal. My family lives here. In part, however, it was prompted by the realization that academic ophthalmology is in worsening trouble nationwide

and that I had proven myself, as chair of ophthalmology at the University of Kentucky, unable to buck the trend. I discovered that I was in good company, for there are currently about 25 open chairs in ophthalmology.

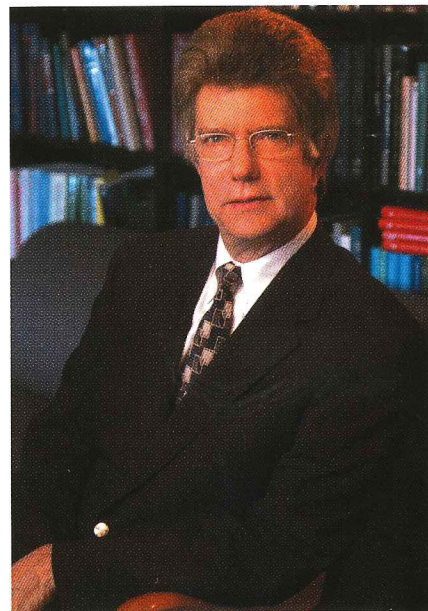
Why is academic ophthalmology in trouble? The same economic forces that have dramatically impacted private practitioners have had an even greater impact on academic medical centers. Traditionally, private practice income has cross-subsidized the academic missions of teaching and research. While the promise of higher salaries, reduced bureaucracy and more control has always lured academicians to private practice, the rewards of original contributions through research and mentoring trainees have been balancing factors. Recently, the equation has become unbalanced. With declining reimbursements that have been felt across the profession, academic departments have been struggling to make ends meet. The dean's tax at most institutions ranges between 8 percent and 13 percent. That comes off the gross clinical income before departmental expenses or salaries. And in most institutions, there is little to no state subsidy.

Because reimbursement is down across medicine, medical school deans have been forced to prioritize their precious resources. Guess what? They are directed toward core departments that they cannot do without: medicine, surgery, pediatrics, obstetrics/gynecology. Ophthalmology cannot compete; we don't even fill hospital beds any more, so the hospital CEO is loathe to commit resources as well. The salvation for some ophthalmology departments is an active development effort, begun by forward-looking chairs of the past. A healthy endowment can allow discretionary spending to shore up the teaching and academic missions.

But for most departments of ophthalmology, the only source of increased income is the shrinking clinical dollar, and faculty incentives are being aligned purely toward pursuit of clinical productivity. Departments embark on clinical expansions, including satellites in the community, or blatant optometric overtures, viewed as competitive threats by the local practitioners. Research and teaching are still mentioned in the mission statement, but when push comes to shove, clinically productive faculty members in remunerative subspecialties

are the only ones rewarded. The result is that research, but most especially teaching, gets put on the back burner. Lectures are canceled, residents are ignored in the press of clinic business, and surgery is performed by attendings because the OR cannot afford the inefficiencies of resident surgery.

It is easy to criticize academic departments; they are not what we all remember. But maybe we ought to reconsider. If our academic departments are failing to adequately teach the ophthalmologists of the future, isn't that a problem for which we must all take responsibility? We need to support our precious academic resource; if it disappears, we will be an endangered species and the patients of the future will be the victims.



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