

2010 ABIM Foundation Forum

# Transforming Medical Education and Training: Meeting the Needs of Patients and Society

By Leslie Tucker

Much has changed in the last 100 years in the delivery of health care. We have seen an explosion in biomedical knowledge and significant changes in the organization of health care; new types of health care professionals have developed and new information technologies have transformed delivery, and there is a growing focus on measured performance and accountability. Yet our approach to medical education and training standardized by Flexner 100 years ago has largely remained the same.<sup>1</sup> With even more changes envisioned with the passage of the Affordable Care Act, what are the expectations for competencies physicians need to develop in training and how can the medical education system support their development?

ABIM Foundation's 2010 Forum: "Transforming Medical Education and Training: Meeting the Needs of Patients and Society" facilitated a multi-stakeholder conversation – with leaders from academic medicine, medical students/residents, patients/consumers, purchasers and policymakers – to assess gaps in the current training environment through the lens of a "social compact" and develop a collective strategy to drive change.

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<sup>1</sup> Cooke M, Irby D, O'Brien B. *Educating physicians: a call for reform of medical school and residency*. Stanford: The Carnegie Foundation for the Advancement of Teaching; 2010.

## FRAMING THE CONTEMPORARY SOCIAL COMPACT FOR MEDICAL EDUCATION AND TRAINING IN THE 21ST CENTURY

The initial work of the Forum was to define the core elements of a contemporary social compact for medical education and training. The notion of a compact between medicine and society derives from the centuries-old tradition in which society confers upon the profession resources and the privilege of self-regulation in exchange for the beneficent services of healers and the assurance that the profession will train its members to the highest standards. The first step for Forum participants was to gain a shared understanding of the reciprocal expectations and obligations that should constitute a 21st century version of this compact between the public and the institutions that support, conduct and oversee medical education and training.

The resulting *Principles of the Social Compact for Medical Education and Training* [attachment] articulates expectations for training the physician workforce needed to support 21st century health care, and what society needs to contribute in turn. The *Principles* affirm many areas of strong agreement about the attributes of the 21st century Caring and Competent Physician advocated by the Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), the Institute for Healthcare Improvement (IHI) and others. They also emphasize competency-based standards and accountability for training outcomes at the individual and workforce levels. Recognizing that learning happens in context, the

*Principles* underscore that training should take place in exemplar environments that make service to their communities an integral part of the training mission. In addition, institutions must also provide for the continuous development of clinical faculty, and engage patients and families in the educational process. In turn, society must provide the medical education and training enterprise with sufficient resources to deliver on these expectations, and align and reinforce its priorities for training outcomes and workforce composition.

## DEEPENING THE CONVERSATION

A second goal of the meeting was to examine the gap between the *Principles* and current reality and to consider strategies for closing it. Presentations spoke directly to the challenge confronting academic medicine: how to sustain the achievement of the world's finest scientifically-based clinical training enterprise while broadening the clinical practice paradigm to include a suite of skills in systems thinking, organizational management, resource stewardship, patient and community engagement and inter-professional teamwork. In short, reconceptualize the professional identity of the physician. At the same time, the overall medical education and training enterprise needs to become more agile in responding to social needs and priorities for the physician workforce.

Drs. Tom Nasca and Darrell Kirch explained how both ACGME and the Association of American Medical Colleges (AAMC) respectively are responding to these twin challenges with major “disruptive” initiatives focused on selection, teaching and assessment of aspiring physicians. That said, the Forum participants acknowledge that the speed and scope of change is constrained by entrenched institutional systems, cultures and business models that both the profession and society have helped to shape and work hard to preserve. They also agreed there is a need for more transparency and accountability for training outcomes and that the overall system needs to become a

continuously learning enterprise that constantly surveys society's needs, enables rapid trials of redesigned educational strategies and facilitates rapid uptake of proven interventions.

Themes from these panel discussions included:

- The pace of change is too slow and we are in danger of having the government step in to more rapidly drive progress;
- Clinical productivity takes precedence over excellence of the learner experience; the “continuum” of education and training is very fractured and the professional community is highly to blame. The concept of “co-learning” of faculty and trainees is key to accelerating knowledge and skill acquisition rather than traditional approaches where the teachers acquire the new knowledge first and then pass it on to students;
- Medical schools have been too resistant to including the social sciences in their curricula; and
- The educational and oversight enterprises have allowed turf issues to get in the way of inter-professional education and training experiences, and programs have not done a good job in helping residents and patients learn how to partner in managing their care and in stewarding scarce resources.

## ADVANCING INNOVATION

The ultimate goal of the Forum was to enlist participants in catalyzing rapid transformational change in medical education and training environments consistent with the social compact. An interactive poster session featuring 20 “early adopters” offered evidence that there is no shortage of innovators and ultimately helped inform the change strategies the participants developed.

Among the innovations presented were:

- A Post-Graduate Orientation Assessment (POA) developed by the University of Michigan to identify and address gaps in the readiness of new interns to safely assume their increased patient care responsibilities and to establish a baseline for performance assessment against educational milestones;

- A program at the University of Missouri that jointly trains health care students and practicing professionals in quality-improvement skills as members of inter-professional teams;

- At the University of Cincinnati, an “ambulatory long-block” that provides trainees with a meaningful 12-month longitudinal training experience in ambulatory settings that has resulted in dramatic improvements in both clinician and patient satisfaction and clinical process and outcome measures;

- A medical education curriculum at the Uniformed Services University of the Health Sciences (USU) that brings the patient voice into education and training by tapping patients to help teach clinical skills to trainees and provide feedback on their performance; and

- A Relationship-Centered Care Initiative at Indiana University that has achieved large-scale culture change at the medical school through changes to admissions criteria, faculty selection and development, and school administration that enabled better alignment of the hidden and formal curricula.<sup>2</sup>

These programs represent only a sampling of the innovations in medical education and training that are occurring because of the creativity and persistent championship of individual program directors/administrators who are committed to achieving a quality learning experience and excellent outcomes.

<sup>2</sup> For more information on these and other early adopters of innovation in medical education and training, see [www.abimfoundation.org/Events/2010%20Annual%20Forum/Innovators.aspx](http://www.abimfoundation.org/Events/2010%20Annual%20Forum/Innovators.aspx)

**What is missing, however, are the strategies and vehicles to widely disseminate these ideas and to translate the most promising ones into general educational practice.**

## CATALYZING REFORM – AN ACTION AGENDA

Forum participants laid out the potential roles and contributions of collaborators in the training pipeline, including certifying and accrediting bodies, education and training institutions, and payers, among others. They then self-organized into teams that identified more than a dozen opportunities to catalyze rapid transformational change. Select ideas from those teams, which are working to advance them, are described below:

- **Learning and Assessing Competencies for 21st Century Ambulatory Practice.** The certifying boards and academic leadership of the three primary care disciplines (Family Medicine, Internal Medicine, and Pediatrics) will launch a joint initiative to accelerate innovation in primary care residency training. The initiative will use the findings from Family Medicine’s Preparing the Personal Physician for Practice (P4) pilot projects to create tri-disciplinary training programs at several sites that focus on teaching the skills – such as teamwork and systems-based practice – that all primary care physicians need to work in high-functioning medical homes. These sites will serve as learning collaboratives for faculty as well as trainees. A second component of the initiative will aim to establish a nationwide primary care faculty training network to equip primary care clinical educators with the tools to assess and improve trainee performance in these “new” competencies.

- **Identify What Works to Transform Primary Care.** A group is planning to bring innovators in primary care together with leading researchers,

foundations and others to evaluate promising new primary care practice models and ascertain the features or components that are most tightly linked to improved care. Academic medical institutions would then be urged to structure the training experience for primary care physicians in keeping with models that demonstrate high performance and physician satisfaction.

■ **Criteria for Redistribution of Graduate Medical Education Funds to Drive Performance and Innovation.** Two groups are working to advance the national policy discussion (catalyzed by MedPAC) about redistributing \$3 billion in Medicare Indirect Medical Education (IME) funds in ways that will stimulate improvement and innovation by the nation’s teaching hospitals. One group is working on a conceptual white paper and a set of performance criteria (quality, efficiency, patient experience) that would serve as the basis for a competitive grant program for teaching hospitals to access additional IME funds. Akin to the National Institute of Health competitive review process, this approach aims to stimulate a “race to the top” among teaching institutions. The second group will align with the Macy Foundation initiative to develop national standards and process measures for graduate medical education that all training organizations would have to meet. A primary objective in the short term is to build political support among academic medical centers (AMCs) for this effort.

■ **Lower Professional Regulatory Barriers to Innovation.** Medical education and training program accreditors and specialty certifying boards are exploring a collaboration aimed at reducing barriers to innovation through stream-

lining professional regulatory requirements for medical training programs and institutions. These professional oversight organizations will identify specific opportunities to synchronize expectations along the continuum of education and training, reduce redundant reporting and other requirements, and encourage experimentation in teaching, curricula and program design.

■ **Promote Inter-Professional Education, Evaluation, Assessment and Accreditation.** This group will develop a call for action for health professional education programs and accrediting bodies at the undergraduate and graduate levels to embed and require inter-professional education. It will request accreditors to set relevant standards and also develop teaching and evaluation tools for educators and reflection tools for trainees. Patients and families would be invited to observe and contribute to inter-professional training.

## MOVING AHEAD

We can not wait 100 years to reform medical education and training. The emerging health care environment demands changes in how the medical education and training enterprise prepares new physicians for practice and how it engages with its largest stakeholder – the public. As the leaders who participated in the Forum undertake to advance a number of important change initiatives, the ABIM Foundation will follow their progress closely, and will make available its ongoing support as connector and convener. Working together in candor and common cause, the profession and the public have the means to transform medical education and training to better meet the needs of patients and society.

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