

Institute for Improving Medical Education
Association of American Medical Colleges

External Advisory Committee Meeting
December 6, 2004

Meeting Summary

The External Advisory Committee for the Institute for Improving Medical Education (IIME) held its first meeting in Chicago on December 6, 2004. All but three members of the committee (Drs. Davis, Deckers, & Drake) were in attendance. Also attending the meeting were Dr. Cohen (AAMC President), Dr. Whitcomb (IIME Director), Ms. Ruffin (IIME Project Coordinator), and Mr. Jon Saxton (Consultant). The meeting, which was chaired by Dr. Michael Johns, followed closely the agenda (see attachment) that had been circulated in advance.

Prior to attending the meeting, each member of the committee had been asked to provide their views on the three most important issues that need to be addressed to begin to achieve the ideal medical education system set forth in the report issued by the Ad Hoc Committee of Deans (“Educating Doctors to Provide High Quality Medical Care”). The responses received from the committee members suggested five major issues of particular concern:

- The content and appropriate length of the medical school curriculum
- The potential for a greater degree of integration between undergraduate and graduate medical education
- Approaches for the assessment of competence at appropriate times during undergraduate and graduate medical education programs and throughout the course of a physician’s practice career
- Reform of the continuing medical education enterprise so that it more effectively and efficiently supports physicians’ effort to remain clinically competent throughout their careers
- The need for a centralized mechanism for monitoring the policies and practices established by individual organizations, which affect how doctors are educated throughout their careers, and for ensuring that they are properly integrated into the country’s medical education system

During the initial discussion of these issues, and others that members of the committee wished to raise, several key points emerged, which generally reinforced the individual views expressed by the committee members:

- The focus of each stage of the educational process must be on preparing doctors to provide high quality medical care
- In order to achieve this objective, substantive changes must be made in the approaches now being used for educating doctors – changes that will require “disruption” of the culture, tradition, and vested interests of individual organizations and professional bodies
- It is essential that new and improved methods for assessing clinical competence be introduced at appropriate times throughout a physician’s education and professional career
- In order to begin to achieve “quality today,” the country’s CME enterprise must be transformed into one that assists doctors in their efforts to provide high quality care in their practices

Working Group Sessions

The working groups that met during the meeting began to cone down on specific issues that need to be addressed to begin to achieve the committee’s objectives. The issues relate to the design and conduct of undergraduate, graduate, and continuing medical education programs; the policies and practices governing accreditation of educational programs; and the licensure and certification of individual physicians. The points summarized below reflect the deliberations of each of the three working groups, as reported to the full committee by the working group chairs.

Undergraduate Medical Education (chaired by Professor Friedlander)

- In order to better prepare students for the roles physicians are expected to play in the evolving health care system, there needs to be more emphasis placed on ethics, the humanities, and informatics both during the undergraduate preparation for medicine and during medical school.
- The biomedical and health sciences must be integrated throughout the entire curriculum in order to provide students with the foundation they need for understanding human biology and disease, and for understanding and applying in their practices the advances that will occur in medicine during their careers.
- The medical school curriculum must be tailored to provide maximum flexibility for students wishing to pursue specific career paths. Schools must define clearly the knowledge, skills, and attitudes that students must acquire in various domains of medicine, and design educational programs that provide opportunities for students to achieve them in an efficient manner. Arbitrarily determined time periods for required courses or clerkships should be eliminated to the degree

possible so that students can advance through the course of study based on their acquisition of core attributes.

- Medical schools must place more emphasis throughout the course of study on the ability of students to access and manage information, rather than their ability to recall facts.
- As currently conducted, the required clerkships do not serve the primary goal of the educational program – achievement of specified knowledge, skills, and attitudes in an efficient fashion. The clinical education of students must be reformed.

Graduate Medical Education (chaired by Mr. Howell)

- Major changes are needed in the design and conduct of GME programs in individual clinical disciplines, in the processes used for accrediting programs, and in the financing of those programs. Because of the many vested interests involved in the GME enterprise, a commission composed of neutral parties may be needed to effect the changes that are needed.
- Those responsible for the clinical education of medical students and the design and conduct of GME programs must seek ways to create a greater degree of integration of the educational processes across undergraduate and graduate medical education. There is a need for the development of demonstration projects that can identify the best ways to achieve this goal within individual institutions and on a regional or national basis.
- There is a need to explore whether a critical number of educational programs are needed within an institution to provide adequate education in different disciplines, whether the size of programs (number of residents) is a critical determinant of program quality, and whether a core faculty is needed to ensure educational quality.
- The design of educational programs should be informed to the degree possible by data on the expected scope of practice of program graduates and the clinical outcomes now being produced by practitioners in the individual disciplines.
- The accreditation of GME programs is badly flawed. The program requirements established by individual Residency Review Committees are overly prescriptive, force micromanagement of the conduct of program activities, and inhibit innovation by sponsoring institutions. Oversight of the development of program requirements by the governing body of the Accreditation Council for Graduate Medical Education (ACGME) is ineffective. The conduct of program and institutional reviews is widely criticized by program directors and institutional officials.

Policy Issues (chaired by Dr. Stobo)

- The accreditation of GME should be modeled after the processes used in the accreditation of the educational program leading to the M.D. degree. Sponsoring institutions, not individual programs, must become the focus of the accreditation process, and a rigorous institutional self-study must become central to the process.
- Steps must be taken to develop new models for residency education in individual clinical disciplines. The accreditation of programs and the certification of program graduates should not be held hostage to the specific program requirements promulgated by Residency Review Committees. Any institution that wishes to engage in a residency redesign process for the purpose of creating a new model for residency training in one or more disciplines should be allowed to do so.
- The current system for evaluating students, residents, and practitioners promotes fragmentation of the medical education system in ways that are detrimental to the education of physicians throughout their education and professional careers.
- The practice of granting physicians an unlimited license for the practice of medicine and surgery before completing residency training must be changed. In accord with that, the timing, sequence, and content of licensing examinations must be changed.
- The continuing medical education enterprise must be reformed to provide a system that will assist physicians in their efforts to remain clinically competent, and the changes needed must inform the development of policies governing the re-licensure and re-certification of practitioners.

General Discussion

During the afternoon session, the committee members engaged in a very rich discussion of the issues that had been raised during the presentation of the working group reports. In general, the discussion affirmed the importance of the points presented by the working groups. The committee members agreed that those points should inform the development of the IIME agenda. Recognizing the scope of the issues that had been raised by the working groups, the committee felt there would be value in setting forth some principles to guide the establishment of priorities for the institute:

- Given changes in the roles of physicians in society and changes in the public's expectations of doctors, the requirements for entry into medical school should be re-examined.
- Given the multiple career paths now being pursued by physicians and the length and cost of a medical education, new models for educating medical students should be developed (demonstration projects). While these models should

provide considerable flexibility in allowing students to pursue major areas of interest, they must retain a commitment to the scientific basis of medicine and provide students opportunities to acquire a foundation of core knowledge, skills, and attitudes in specific domains of medicine.

- The clinical education of medical students must be redesigned to provide opportunities for students to achieve predetermined learning objectives for clinical medicine without adherence to the traditional clerkship model that assigns students to various rotations for predetermined, arbitrary periods of time. The assessment of student performance against specific learning objectives should determine the design and conduct of the clinical education experiences.
- There needs to be a better understanding of how the clinical education of medical students and the early education of residents can be better integrated in individual clinical disciplines to ensure that students are properly prepared for residency and that the expectations of residency faculty are aligned with actual experiences. Demonstration projects are needed to determine how this might best be accomplished within an institution or on a regional or national basis.
- The continuing medical education enterprise must be changed in accordance with evidence of the kind of educational experiences that are most likely to affect physicians' practice behaviors and the clinical outcomes of the care they provide. Major changes are needed in the policies and practices of organizations, which affect the design and conduct of CME offerings, and those that affect how CME is used in determining eligibility for re-licensure and recertification.
- Position papers, as well as other strategic options, should be employed to raise within the medical education community and other interested communities, a sense of urgency for the need to make fundamental changes in the ways doctors are educated in this country.