Social Accountability Across the Continuum of Medical Education: A Call for Common Missions for Professional, Accreditation, Certification, and Licensure Organizations

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The continuum of medical education is long and fragmented and in need of significant reform. This column provides a rationale and plan for a summit of leaders of professional organizations and bodies of accreditation, certification, and licensure to discuss one step in the reform of the continuum—the development of common missions based on measures of social accountability.

The Problem
The production of physicians is a long, arduous, fragmented, and expensive process. The transitions of education from university pre-medical studies to medical school, from medical school to residency, and from residency to practice and continuous professional development have strict boundaries that are governed by distinct accreditation, licensing, and governing bodies. The process is not governed by a common goal of social accountability, and this contributes to a health care system that has worse than expected health care outcomes at high monetary costs. The educational debt load for new physicians is high, and duty hour regulations have caused residency programs to struggle to maintain comprehensive education for resident physicians. There is pressure to lengthen residency training; however, economic factors that affect physician specialty choice and workforce imbalance suggest that a more efficient and less lengthy continuum, particularly for primary care specialties, may be optimal for a physician workforce that will result in better system effectiveness, efficiency, and equity. Change in the continuum will likely occur through only two mechanisms: (1) financial incentive to change and (2) change in accreditation, certification or licensure requirements.

Synopsis
In the past 2 decades, problems with the continuum of medical education have been noted repeatedly by many educational experts and organizations, including the Association of American Medical Colleges (AAMC), the American Medical Association, the Royal College of Physicians and Surgeons of Canada, the Association of Faculties of Medicine of Canada, the Medicare Payment Advisory Commission, the Council on Graduate Medical Education, and several influential private foundations. These organizations collectively recommend a comprehensive process of evaluation of the system of medical education and call for shortened overall training period for physicians; a common mission of social accountability for accrediting, licensing, and certifying organizations; competency-based systems of education and continuous professional development; earlier points of specialty differentiation in medical education; training standards with less rigidity, more innovation, and more responsiveness to societal needs; more training in ambulatory settings; and more time with mentors and supervisors. Several have recommended a summit of accrediting, licensing, certifying, and
professional organizations to begin a comprehensive evaluation of the continuum. A focus on collaborative efforts of accrediting, licensing, and certifying organizations to develop a common mission based on social accountability will be the initial step most likely to spur a wider ongoing process of improvement of the continuum of medical education.

**The Proposal**

I have proposed an initial 1-day summit for a small number of stakeholders to begin the dialogue that will eventually lead to a comprehensive evaluation and overhaul of the continuum of medical education. The goal of the initial summit will be to engage representatives of accrediting, licensing, certifying, and professional organizations in a dialog to address social accountability across the continuum of medical education.

**Background**

For some time, the continuum of medical education has been a topic of discussion. In the 1920s, the AAMC sponsored a commission on medical education whose final report included recommendations that the course of study for medical students be less rigid and provide more independent learning. It criticized overcrowding and lack of balance in the medical school curriculum. This debate has continued to the present. In 1994, AAMC President Robert Petersdorf wrote:

> Perhaps if we are successful in moving more clinical education into ambulatory settings we will see a resurgence of interest in careers in the generalist rather than specialty disciplines. Our medical schools present overproduction of specialists is a grave disservice to our society. Medical education is frequently described as a continuum, but a true continuum... is ‘something in which a fundamental common character is discernible amid a series of insensible and definite variations.’ Regrettably, there is no such fundamental common paradigm in medical education today. The components of medical education—college preparation for the study of medicine, medical school leading to the award of the MD degree, an intense period of clinical training known as residency, and scattered continuing medical education experiences throughout the practice years—are like children’s building blocks. They are piled one atop another to make a tower that from a distance may look like a coherent whole but from a closer perspective reveals a discrete nature of the components that are a fragmented overall structure. I suggest that the fundamental common characteristic of medical education should achieve the objective of producing independent self-motivated learners, prepared for a practice of medicine that is relevant to the needs of the community in which the physician will serve.

The words of Dr Petersdorf clearly outline the problem, which has not been addressed substantively in the 18 years since he wrote them. The continuum of medical education is fragmented, disorganized, and expensive. In addition, there are few scholarships for underrepresented minorities or those who have economic or educationally disadvantaged background, and the economic pressures that move medical education away from social accountability have increased.

There are five distinct periods that require educational transition for physicians in the continuum of medical education: (1) the preprofessional pipeline, (2) university premedical studies, (3) medical school, (4) graduate medical education, including residency and fellowship, and (5) continuing professional development.

The Future of Medical Education in Canada white paper notes:

> These periods of transition are fairly rigid demarcations governed by distinct accreditation, examination/assessment processes and governing organizations. These transitions require the person [in the medical education continuum] to reform their way-of-being and identity in fundamental ways as the person assumes new roles and meets new expectations. While the transitions are acknowledged, little attention has been paid to the transitions in the way that they can be eased to optimize success.²

Further, the accrediting, licensing, and certifying organizations that govern these transitions of education are independent organizations, with self-perpetuating boards, and independently developed missions that often do not address societal needs or the transitions of education.

The issue of social accountability across the continuum is particularly relevant for the discipline of family medicine. Duty hour regulations, and other factors, strain residency programs in their mission to train physicians who provide comprehensive care. To address this issue, there is now experimentation with 4-year residency training programs. If the
Committee, COGME wrote the following:

Committee, and to the House Ways and Means Commerce Committee, to the Senate Finance Pensions Committee, to the House Energy and Commerce Committee, to the Senate Health Education, Labor and Pensions Committee, to the Senate Finance Committee, and to the House Ways and Means Committee, COGME determined that health care outcomes and costs are optimized when at least 40% of the physician workforce was made up of primary care physicians. The PCEM found that this percentage is currently 32% and that only 15% to 20% of recent graduates of US allopathic schools of medicine plan careers in primary care disciplines. Even though a longer course of residency training may produce a better educated family physician, such policy may actually result in a system with worse population-based outcomes and higher costs and thus could actually be a detriment to society.

Both the Medicare Payment Advisory Commission (MedPAC) and COGME have made recommendations for a summit to evaluate the continuum of medical education. In a November 14, 2011, letter to the Secretary of HHS, the Lewin Group presented findings from their recent study, the Primary Care Entrant Model (PCEM). Some of the findings are published in the COGME 20th Report. The PCEM evaluated over 20 years of data and predicts that a lengthening of the continuum would cause fewer students to choose careers in primary care and family medicine. COGME determined that health care outcomes and costs are optimized when at least 40% of the physician workforce was made up of primary care physicians. The PCEM found that this percentage is currently 32% and that only 15% to 20% of recent graduates of US allopathic schools of medicine plan careers in primary care disciplines. Even though a longer course of residency training may produce a better educated family physician, such policy may actually result in a system with worse population-based outcomes and higher costs and thus could actually be a detriment to society.

In 2011, a series of presentations at the Family Medicine Education Forum of the Section of Teachers of the College of Family Physicians of Canada suggested that the continuum of medical education in North America needs to be retooled and reworked. It was proposed that the governing and licensing bodies of medical education in North America link accreditation and licensure to social accountability and develop a common mission statement, with language proposed in 1995 by the World Health Organization. The WHO defined the social accountability of medical schools as “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve.”

**Potential Actions to Improve the Continuum**

Several actions, listed below, may improve the continuum of medical education:

1. A common mission statement of social accountability for governing, accrediting, and licensing bodies
2. Greater emphasis on collaborative and team-based care in education
3. More time in residency programs, with less time in premedical and medical school studies and less rigidity and more emphasis on creativity in accreditation standards
4. More time in mentoring relationships and in ambulatory-based care
5. More emphasis on competency-based evaluation at all levels
6. More emphasis on leadership development in the continuum at all levels
7. Structured support for students at all levels of transitions of medical education
The initial step will be a summit to examine the first action, a common mission statement of social accountability for governing, accrediting, and licensing bodies. In addition to professional organizations and other stakeholders, the discussion of mission statements of social accountability will involve leaders from the Liaison Committee for Medical Education, the National Board of Medical Examiners, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties, the various osteopathic organizations with related functions, and the Federation of State Medical Boards. Follow-up meetings after the first summit may then explore specific innovative approaches to the other suggested actions.

References

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