

## Medical Education Reform – A Joint Endeavor?

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Dr. Whitcomb shared some thoughts regarding how the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) might work together in rethinking the way physicians are trained throughout the continuum. He mentioned that this past June, at the joint meeting of the AMA Council on Medical Education and the Section on Medical Schools, Dr. Jordan Cohen, AAMC President and Dr. Michael Maves, AMA Executive Vice President and CEO entered into a “Statement of Cooperation.” Dr. Whitcomb read the following section of the Statement:

“By collaborating, the AAMC and the AMA can maximize their efforts to assure the public that future physicians are optimally prepared to meet the challenges of the 21<sup>st</sup> century. Our goal is to ensure that physicians are prepared to provide high quality patient care in the context of our nation’s needs.”

Dr. Whitcomb remarked this is a “lofty goal” and one that both organizations need to be absolutely committed to. Historically, the AMA and AAMC have been instrumental in working together on a number of issues related to the transformation of medical education in the United States and importantly continue to be the two organizations that are responsible for the Liaison Committee on Medical Education, which does an outstanding job, according to Dr. Whitcomb, in its efforts to help institutions/medical schools to enhance the quality of the education programs that they conduct. The question is whether the AMA & AAMC can maximize efforts to assure the public that they are actually meeting the needs of patients and not simply serving the profession’s own self-interest.

According to Dr. Whitcomb, the real challenge is that there is an extraordinary number of organizations that touch, in one way or another, medical education. Not only touch it but also feel that they have certain rights as it relates to some aspects of the medical education system. It is an issue that is very well described in The Blue Ridge Academic Health Group Report, “Reforming Medical Education: Urgent Priority for the Academic Health Center in the New Century,” and the AAMC’s Report of the Ad Hoc Committee of Deans, “Educating Doctors to Provide High Quality Medical Care: A Vision for Medical Education in the United States.” Most organizations tend to look out for their own interests, said Dr. Whitcomb, so it will be an important challenge for the AMA and AAMC to cooperate to find meaningful solutions to reform medical education.

One of the practical challenges that Dr. Whitcomb sees the AMA and AAMC facing is the fact that there is a significant asynchrony in the timing of the AMA and AAMC initiatives to reform medical education. The first event for the AMA will be a “town hall” meeting scheduled for December 6-7, 2005 with participants drawn from a variety of backgrounds coming together to share what they view are the problems with medical education in this country. This is the first public event of AMA’s initiative outside of discussions with the AMA staff and its leadership. The AAMC has been addressing the issue for some time. In the fall of 2002, the AAMC’s Institute for Improving Medical Education (IIME) was established. Before the AAMC determined an agenda for the Institute, they established the Ad Hoc Committee of Deans, chaired by Dr. Joseph Martin, and disseminated the 2004 Report that was

previously mentioned. The Report was adopted by the AAMC Council of Deans Administrative Board in Spring 2004 and has provided the guidance for the Institute's agenda.

The Report charged the AAMC to engage in two major activities: 1) To catalyze innovations in medical education and 2) To catalyze changes in policies affecting adversely the performance of the medical education system. The role that the AAMC would play would be of convener, partnering with other organizations very much consistent with the spirit of the "Statement of Cooperation" with the AMA.

The model that the AAMC has used to catalyze innovations in medical education has been to partner with a foundation or a government agency to create a small grants program. An RFP (request for proposal) was issued asking medical schools how they would modify their curricula in an innovative way. Currently there are 5 curriculum integration grant programs underway and the foci are:

- Chronic illness care (Macy Foundation)
- Cultural competence (California Endowment)
- Population health (Centers for Disease Control [CDC]/Milbank Fund)
- Interdisciplinary education (McCann Foundation)
- Clinical skills (Macy Foundation/New York Academy of Medicine)

Prior to these particular activities, the first of the models used by the AAMC was the Hartford Foundation grant on gerontology and geriatrics. By the end of the grant, 40 medical schools had participated in that initiative and the results were published in the July 2004 supplement of *Academic Medicine*. It represents, in terms of the number of institutions involved, the largest curriculum modification project ever conducted in this country. Ultimately, Hartford contributed 5 million dollars to the initiative and the AAMC is now engaged in follow-up activities related to the project.

The chronic illness care initiative will fund 10 medical schools and 10 residency programs in internal and family medicine and it's the AAMC's hope that 5 of those schools will look at chronic care across the continuum. The cultural competence grant has awarded funds to 4 California schools with funding coming from the California Endowment. The population health grant has one initiative underway that is creating regional centers with funding going to 7 medical schools. This grant will most likely fund another 5 or 6 schools, if the AAMC gets final approval from the CDC. The clinical skills exam project has 6 medical schools involved in this activity - the one that has received the most attention is the Cambridge integrated curriculum.

The AAMC has also issued reports, under the umbrella of the Medical School Objectives Project. The goal has been to catalyze innovations within the medical schools and create models that other institutions can use to inform their own thinking about how they might change their curriculum to address some of these important contemporary issues.

The big challenge has been the second charge of the Ad Hoc Committee of Deans and that was to catalyze change in policies. Why this is such an incredible challenge is because those policies are policies of other organizations and it gets into some very interesting political issues. It is a major problem simply because of the number of organizations that are involved, many of whom are not very open to hearing constructive criticism on how they might positively change their policies.

Dr. Whitcomb read a quote that he said he heard as a medical student and was made famous in the political arena by Robert Kennedy - "Some see things as they are and ask why, others see them as they

might be and ask why not.” Dr. Whitcomb stated that it is important for organizations to advocate for what is in the best interest of patients, not necessarily what is in the best interest of the organization.

The even bigger challenges, according to Dr. Whitcomb, are related to the remaining parts of the continuum – graduate medical education and continuing medical education. The AAMC is successful in working with medical schools because it is a finite number, manageable, and the schools are members of the AAMC. AAMC staff work closely with staff in the deans offices, so when the AAMC wants to discuss a particular issue impacting medical education, there is some willingness on the schools’ part to be engaged because it’s viewed as an expectation of being an AAMC member.

There are many concerns regarding graduate medical education in this country, particularly whether the resident physicians are being adequately trained for medical practice - are the training sites appropriate? The internal medicine, family medicine, surgery, and pediatric communities have all issued reports saying that the current approach to residency education is not adequate - yet none of these groups, according to Dr. Whitcomb, have changed how they approach education after issuing their reports.

What can be done? How can leverage be brought to bear to get away from the internal squabbles that take place? Dr. Whitcomb mentioned as an internist he has seen that the American College of Physicians has a particular view on what is needed to reform internal medicine, the American College of Internal Medicine has a view, the internal medicine professors have a view, and they can’t seem to resolve the issues in terms of the way they think the residency training programs should be organized because they all have individual stakes in the outcomes. So the internists have been at it for a couple of years and have been unsuccessful. The surgeons established a blue ribbon committee, developed a report, have had an opportunity to present the findings at various meetings, and yet the concepts for change haven’t taken hold - there are many internal problems that still need to be resolved.

Another concern is the role of the Accreditation Council for Graduate Medical Education (ACGME), and more specifically the Residency Review Committees (RRC’s). Dr. Whitcomb says the problem is that the RRC’s are promulgating requirements that are inconsistent with the realities of what is needed for resident education. For example, the Pediatrics RRC recently decreased the amount of time required in ambulatory care settings and increased the amount of time in critical care units. What is the logic behind this change, Dr. Whitcomb asked? Also, the future practice of the general internist is not going to be hospital-based so shouldn’t the resident physicians be educated in the environment they will be practicing in?

The ACGME is an independent body, it has 5 member organizations that now have really very little ability to influence what happens within the organization, according to Dr. Whitcomb. Dr. Cohen has recommended to the ACGME that there be an external review conducted. This request, according to Dr. Whitcomb, doesn’t seem out of line given the fact that the ACGME makes its living doing external reviews so why not have an external review themselves, but to date the ACGME hasn’t been willing to engage in that activity. Dr. Whitcomb believes we are not going to be able to make the kind of changes that are necessary unless the requirements for training are appropriately changed.

Continuing medical education is another major problem according to Dr. Whitcomb. By the time an individual has entered practice, he or she, on average, has at least 3 decades of practice in front of them. There is a growing body of data that states the quality of care provided to patients with chronic conditions is almost a coin flip in terms of whether it meets expected standards. Recent studies have shown that there are differences in the care being provided based upon how long a physician has been in practice. A good example is hypertension – the number one chronic condition in the country. Dr. Whitcomb said

when he was a resident in internal medicine there were only 3 drugs available to use to treat hypertensives and 2 of them made patients sicker than when they first came to see the physician. Now there are many categories of drugs and multiple drug regimens used. It is an incredible challenge to be able to stay up-to-date. Dr. Whitcomb mentioned that in the field of pulmonary medicine, there have been numerous changes that have occurred over time in the treatment of asthmatics. The question that needs to be asked is whether or not the current continuing medical education enterprise serves the interest of physicians as they try to maintain their clinical competence and serve the interests of their patients. The Cochrane Studies data show that the predominant form of continuing medical education, attending lecture type courses, does not influence the way physicians practice - doesn't change practice behaviors. Yet it remains the predominant approach to the continuing education of physicians once they get into practice.

The AAMC thinks that the AMA Physician's Recognition Award needs to be reformed because it drives what happens in CME. The definition of what is a category 1 experience creates the currency that physicians need for relicensure and hospital privileges. Currently, the highest rating goes to attending courses and Dr. Whitcomb asked why should it when the data show that those courses don't affect practice behaviors? The AAMC thinks that the Accreditation Council for Continuing Medical Education (ACCME) needs to be reformed. Why is it that the ACCME accredits only those providers that offer courses - does that make sense? Is that serving the interest of physicians and their patients? What kind of CME system do we need? There is a fair consensus on the kind of system needed. The question is whether the profession wants to make the necessary changes? Can the profession partner with the appropriate organizations to make the changes happen?

If one reviews the history of medical education reform in this country, one will see that the bulk of what has been written has been on the education of medical students. The least attention has been paid to CME and it is the most important aspect of the continuum, according to Dr. Whitcomb. He thinks that if the profession wants to improve the quality of care provided by physicians, then as a community, physicians have to reform the existing CME system. They have to create a system based upon the evidence that is available. CME should be based on an assessment of individual needs, utilizing active formats, and be office-based. Dr. Whitcomb noted that a few years ago the National Health Services in the UK stopped reimbursing general practice physicians who attended conferences, but instead gave them funds to work on quality improvement initiatives in their practices. In Canada, there is also an office-based CME system. Unfortunately, in this country, the profession continues a system in which if a physician wants to renew his/her license they need a certain number of category 1 credits, in the jurisdictions that require it, and in order to get those credits most physicians will end up taking courses.

Also what is interesting, according to Dr. Whitcomb, is that to get relicensed most physicians can go to any course they want regardless of their specialty as long as they get a certificate stating they received category 1 credits. It has become the currency that exists in most jurisdictions or hospitals for privileging and for certification. So what does the profession need to do to change the system? According to Dr. Whitcomb, the AAMC and AMA leadership needs to commit to achieving meaningful reform of CME within the year - not 5 years, not 10 years, but within the year. It's time to stop talking about the issue and do something. The AAMC has policy, which was recently reaffirmed. It has developed a proposal on how reform should proceed, and it is important that the AAMC partner with the AMA so the likelihood of having success is much greater. Dr. Whitcomb hoped that the AMA leadership and the SMS would give serious consideration to the AAMC's proposal. What he proposed, in the spirit of the "Statement of Cooperation," was to establish a joint task force that would study how to change the AMA PRA. Dr. Whitcomb thought the definitions needed to change and how they are applied. The AMA Council on Medical Education, several years ago, actually committed to making fundamental changes in the AMA PRA, but Dr. Whitcomb didn't feel the changes were yet satisfactorily implemented. The joint

task force needs to address the entire accreditation process. The organizations need to discuss what the vision should be and how to go about achieving that vision.

Dr. Whitcomb mentioned that at the last meeting of the external advisory committee of the Institute for Improving Medical Education, after hearing presentations from the FSMB, ABMS, and AMA, some of the participants thought the ACCME should be “abolished.” How will the ACCME, as the organization currently exists, accredit providers who will be creating the kinds of in-office experiences that physicians will need for CME credit?

Dr. David Davis, a leading authority on CME based in Toronto, is joining the AAMC as a Petersdorf Scholar-in-Residence and Dr. Davis will spend the next 6 months talking to many people in the medical community to redesign the CME enterprise built upon what is known to work from the evidence that has been gathered. The question posed to physicians will be how would you manage the CME process in a way that would satisfy the public that physicians are being responsible and that there is accountability built into the system.

As previously mentioned, Dr. Whitcomb thought it would be reasonable to have a joint task force that would serve as an advisory group to Dr. Davis – experts he could bounce ideas off. In terms of CME reform, the real question is who will lead? What Dr. Whitcomb proposed is that the AMA and AAMC lead, building on the “Statement of Cooperation,” and building on past experiences. The question is whether the organizations are willing to work together on this important issue. Dr. Whitcomb mentioned that a meeting was planned for December 2005 where he will be talking with the key AMA stakeholders to discuss this very issue. A key question for the AMA and AAMC is whether the organizations are willing to withstand criticisms from others. Dr. Whitcomb thought that many organizations will criticize the effort regardless how affective it might be simply because they aren’t a part of it or don’t think the AMA and AAMC should take the lead. Are the AMA and AAMC willing to use public pressure to effect the needed changes?

Dr. Whitcomb remarked that the public has a major stake in this initiative and they have an absolute right to know what the current situation is and be able to respond through its appropriate representatives and others who are concerned about the quality of care being provided in this country. If the AMA and AAMC don’t lead, maybe the government should lead. Maybe state medical boards should lead the activity. That would change things quickly, thought Dr. Whitcomb. The Centers for Medicare and Medicaid Services (CMS) could decide that they are not going to go along with the current CME system, and in order for doctors to be paid for the services they provide, CMS will need documentation that physicians participated in affective CME based on evidence. The Veterans Administration or the military could require the same thing. So it’s a legitimate question, if the profession doesn’t move forward in meeting its responsibilities than maybe the government should step in.

In closing, Dr. Whitcomb remarked that it is almost a 100 years since the Flexner Report was issued. While the focus of the Report was on the state of medical schools and the education that those schools were providing, Dr. Whitcomb thought that the concerns expressed then can legitimately be applied to the current concerns about residency education and continuing medical education in this country. Dr. Whitcomb expressed his desire to have the AMA and AAMC link arms, in the spirit of the “Statement of Cooperation,” and try to initiate meaningful changes to the GME and CME systems, within the near future, not years from now.

## **FSMB/State Medical Board Initiatives and Policies that Impact CME**

### **Speaker**

*James N. Thompson, MD*

*President and CEO, Federation of State Medical Boards*

Dr. Thompson began his presentation with an overview of the Federation of State Medical Boards (FSMB) and then proceeded to explain how state medical boards can play a role in some of the continuing medical education revisions that Dr. Whitcomb addressed.

Dr. Thompson mentioned that the FSMB is a non-profit organization whose mission is the “continual improvement in the quality, safety, and integrity of health care through the development and promotion of high standards for physician licensure and practice.” Their motto is “to protect the public.” The Federation is the membership association of the 70 state medical boards. Fourteen states have separate boards for osteopathic physicians. Also included are the boards from the 4 territories of Puerto Rico, Guam, Virgin Islands, and Mariana Islands and Washington, DC. New York has 2 seats because they have a licensing authority that reports to the Department of Education and a regulatory authority that reports to the Department of Health and no formal means of communication between the licensing and discipline aspects.

The FSMB is a co-owner of the USMLE (medical licensure examination) with the NBME (National Board of Medical Examiners). That happened in the early 90’s when the FLEX (federated licensing examination) and the National Certifying Examination came together to have a single pathway to licensure for MDs in this country. The FSMB also offers post-licensure assessment services. They have a credentials verification service that is a one-time verification of core credentials so when a physician seeks licensure in multiple states they don’t have to have their credentials reverified. Increasingly this service is going to be used in hospitals for credentialing as well as managed care organizations.

The FSMB has the largest database in the nation on physician disciplinary actions. They now provide a disciplinary alert service, which notifies every state in which a physician is licensed anytime a disciplinary action is taken against that physician. In years past, someone could be convicted of a felony in one state, simply move into the next state where they had a license, hang up a shingle, begin practicing, and no one would be the wiser. Now the FSMB notifies state medical boards of those decisions. They provide education services, have a number of publications, and much of this is available on their Web site.

Dr. Thompson remarked that the FSMB is increasingly involved in research and policy development. In fact, they are in the process of a search for a vice president of research and analysis for its first office of research regarding health policy. They also service the secretariat for the International Association of Medical Regulatory Authorities.

Regarding professionalism, Dr. Thompson stated he particularly likes the American Board of Internal Medicine’s definition in which they refer to it as the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity. Dr. David Blumenthal wrote in *Health Affairs* in 1994 about professionalism and he described it as the “legal, institutional, and moral privilege that is granted by

society and that must be earned by health care providers through observing certain standards of behavior, including at least altruism, placing the interests of our patients above our own self interests, commitment to self improvement, and peer review.” In that peer review, because of the specialized knowledge that physicians have, they are uniquely positioned not only to supervise the work of their peers but to protect consumers against failures of professionalism.

A joint statement from the American Medical Association and the FSMB was offered in 1995 and it states that state medical boards are charged, by state law, with the ultimate responsibility for assuring the quality of care provided by licensed physicians. The Boards are directly accountable to the public for this activity. Every state has a chance to regulate and license the practice of medicine. Thus state boards have a triad of protecting the public and that triad includes licensure, regulation and discipline. Dr. Thompson made note that the profession needs to continue to remind medical students that licensure is a privilege not a right. Licensure is used to evaluate an individual’s competency to practice medicine. The medical profession in this country decided well over a century ago, that it would separate the assessment for graduation of medical school from the assessment for licensure, which is why there is a licensing examination.

In licensure, character does count. In regulation, the boards establish standards for physician licensure and practice and they take appropriate action against individuals who have crossed the line, who have violated elements of the medical practice act. The second leading cause of physician discipline is unprofessional conduct. In Dr. Maxine Papadakis’ article in the March 2004 issue of *Academic Medicine*, she reported on her study which looked at predictive factors in medical school that would indicate which medical students are likely to have disciplinary actions taken against them. There is some follow-up research in other medical schools that is substantiating that claim. The most consistent predictive factor is evidence of unprofessional behavior during the 4 years of medical school.

The FSMB has defined competence as possessing the requisite abilities (qualities, cognitive/non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards. Dr. Thompson remarked that there are deficiencies in the current system. One of the ways that the profession relicenses physicians is to require that they have a certain number of hours in continuing medical education. There is no assurance that a physician is maintaining his or her competence. Much of the actions, Dr. Thompson thought, are reactive. The profession responds when a physician simply crosses the line, shows gross incompetence, or has committed behavior that violates the medical practice act. Clearly there is a lack of collaboration between the different organizations in looking at maintaining a physicians competence. So not only the profession, but others, have recognized the need for a change to better protect the public.

Many jurisdictions require physicians to engage in CME and of those that do there is considerable variation not only in the number of hours but some have content specific CME. With 24 medical boards that accept the AMA Physician’s Recognition Award, in lieu of CME, the actual requirement for CME ranges from as little as 20 credits annually to 150 credits every three years, so there is considerable variation. Some states have a particular topic that a legislator may decide is important for every physician in that state to be trained in, so they will have mandatory CME, such as in pain management, ethics, HIV. So the profession is somewhat at the whim of legislative initiatives. Dr. Thompson noted that only 2 of the 70 medical boards actually have a requirement that some of the CME be in the area of a physicians practice.

In 2001, the FSMB Board approved a recommendation to the Accreditation Council for Continuing Medical Education Content Validation Task Force to consider the following elements in defining valid CME:

- Be evidenced-based, scientific, current, objective, and presented in an unbiased format
- Have objective, measurable outcomes – that is, data evidencing positive practice changes
- Promote the efficient and effective practice of medicine in a physician's area of expertise
- Be a positive part of a physician's practice and involvement in lifelong learning and maintenance of competence
- Promote quality health care by informing physicians of what denotes quality
- Be a tool to educate physicians about potential errors and to promote safe practice
- Be a credible mechanism for public assurance of a physician's continual maintenance of competence

These are basically the same objectives that the AAMC are working toward. There are 2 major threads that seem to run through future CME, 1) The shift toward competency-based assessment and 2) Assuring maintenance of physician competence.

In May 2004, the FSMB House of Delegates passed and adopted the following statement, "State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure." This is a major change for state licensing boards because in the past they have only been involved in initial licensure and making sure that physicians send their money in time to renew their licenses and taking care of physicians who were referred for quality or behavioral problems for disciplinary action. Ensuring competence is a task that state medical boards cannot and do not have the wherewithal to do among themselves.

In 2003, the FSMB established the Special Committee on Maintenance of Licensure whose charge included evaluating the responsibility of state medical boards for ensuring physician competence throughout the course of a physician's career and the efficacy of methods used to carry out these responsibilities. The Special Committee affirmed the belief that CME, as currently mandated by state medical boards, helps to facilitate continued competence. However, the Committee felt that CME, as it is currently structured and utilized by state medical boards, remains inadequate to verify or ensure continued competence.

To supplement this House policy and the Committee's activity, the FSMB held a national summit in the spring 2005 and the second summit is planned for December 2005. At the March summit, 34 health care organizations were represented. It was a very successful summit in which the participants went through an exercise of scenario planning. Dr. Thompson encouraged the audience to view the Web site, [Innovationlabs.com/summit](http://Innovationlabs.com/summit) for a summary of scenario planning. This exercise looked at the future of physicians' self-regulation and began a dialogue that will be useful for organizations dealing with maintenance of competence. There are some key principles, however, that are important in any kind of maintenance of licensure just as there are in the maintenance of certification (MOC) process. One is to avoid duplication. The ABMS has a committee looking at MOC and the FSMB has a committee to look at maintenance of licensure. The chairs of each of these committees sit with the opposite committee so there is direct communication to avoid duplication. It also should not be overly burdensome for physicians and should be accompanied by remediation and be non-punitive.

It is not just the medical profession that recognizes change is necessary, the profession is being challenged from outside organizations to look at making changes. The FSMB did a public opinion poll

several years ago - physician competence was rated as a concern of the public just behind disciplining bad physicians.

Today's physician must stay current by learning smarter, not working harder. It's critical for the medical community to share the responsibility of this lifelong learning process. The state medical boards, within themselves, certainly don't have the resources to assure the public and it will require a national CME system that will not only support the physician's efforts for periodic re-licensing, re-credentialing, re-privileging and re-certifying, but will allow for the public to be assured that the profession is doing all that it can to make sure that physicians are maintaining their competence.

Dr. Thompson briefly discussed the Conjoint Committee on CME and said that the 14 represented organizations developed the following vision statement: "CME is an essential element in lifelong physician professional development and continuous improvement, and must facilitate appropriate learning for optimum patient care." The Conjoint Committee said that effective CME for physicians should:

- Enhance quality care
- Support professional activities
- Assess professional/educational needs
- Evoke professionalism
- Motivate learners
- Produce measurable outcomes

The Conjoint Committee on CME developed 7 recommendations for change in the following areas:

- Medical education continuum
- Self-assessment and lifelong learning
- Core curricula and competencies
- Valid content utilizing evidence-based medicine
- Performance and continuous improvement
- Metrics to measure and recognize learning and behavioral change
- Resources and support

Dr. Thompson concluded by saying the challenge will be who is going to pay for this proposed office-based CME and who will be the providers in a system that may be very different from the current system? He said he looks forward to the discussions regarding the future of CME and is grateful that the Section has agreed to tackle this very difficult issue.