

2010 ABIM Foundation Forum

Principles of the Social Compact for Medical Education and Training

The 2010 ABIM Foundation Forum, ***Transforming Medical Education and Training: Meeting the Needs of Patients and Society***, brought together more than 160 of America's health care leaders to envision and articulate the principles of a contemporary social compact for medical education and training. Leaders in academic medicine, certifying and accrediting organizations, practicing clinicians and trainees came together with patients, consumers, payers, policymakers and others to define the attributes of the Caring and Competent Physician who is well prepared to practice in tomorrow's high-performing health care systems and the expectations of a 21st century medical education and training enterprise that flow from that definition.

The Social Compact

The notion of an implicit social compact for medical education and training flows from a centuries-old theory of a social contract between society and the medical profession, in which society confers privileges, resources and regulatory autonomy in exchange for the contribution of healers to the public good and a commitment by the profession to ensure the competence of its members.¹ In modern times, the social compact for medical education and training is also considered by many to include public accountability of academic medical *institutions* in exchange for the substantial public funds that they receive to support their teaching missions.²

A confluence of historic events makes this the right time to re-envision the expectations of the social compact:

- The nation finds itself preparing to implement an ambitious national health care reform bill that will transform the way health care is delivered and offer a test-bed for training innovations;
- The 100th anniversary of the landmark Flexner Report, which revolutionized medical training; publication of its successor, *Educating Physicians*, by the Carnegie Foundation, along with critical reflections by other thought leaders in academic medicine;
- New leadership in key federal agencies whose policies help shape the training environment;
- A consumer-driven push for transparency and accountability in all aspects of public and commercial affairs, including health care; and
- The nascent reforms already underway in many medical disciplines.

¹ Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. *Acad Med.* 1997;72:941-952.

² McCurdy L, Good L, Inui T, Daugherty R, Wilson D, et al. Fulfilling the social contract between medical schools and the public. *Acad Med.*, 1997;. 72:1063-1070.

The Challenge for Medical Education and Training

The overall goal for the U.S. health care system is to improve the health of the population by safeguarding and improving the health of each individual. The system aims have been articulated by the Institute of Medicine (IOM) (safety, timeliness, effectiveness, efficiency, equity, patient centeredness) and by the Institute for Healthcare Improvement (IHI) (improve the health of the population, enhance the patient experience of care and reduce, or at least control, the per capita cost of care).

Few would deny that the nation's medical education and training institutions admirably serve the public good by training a cadre of highly skilled physicians, continuously advancing medical practice through new therapies and treatments and advancing the basic sciences to further our understanding of disease. However, many suggest that this enterprise has not evolved apace with the opportunities to achieve health system aims; that it is no longer producing a physician workforce that is well matched to society's needs,³ and that it falls short of equipping individual clinicians with the knowledge, skills and attitudes that are essential to contemporary practice. Contemporary physician competencies include a focus on population health; the use of data and information management tools for practice improvement and evidence-based clinical decision support; teamwork and communication skills; and leadership within complex systems. These are the skills essential to effect the transformation of medicine from "a cottage industry to a post-industrial health care system."⁴

The Principles of the Social Compact for Medical Education and Training presented in this document reflect and incorporate the work of a dedicated and insightful group of leaders. These Principles will serve as a guide to evolve medical education and training to meet the needs of our changing health care system.

³ Medicare Payment Advisory Commission Report to the Congress: "Aligning Incentives in Medicare" June 2010.

⁴ Swensen SJ, Meyer GS, Nelson EC, Hunt GC, et al. Cottage industry to postindustrial care – the revolution in health care delivery. *N Engl J Med.* 2010; 362(5):e12(1)-e12(4).

Principles of the Social Compact for Medical Education and Training in the 21st Century

I. Public Expectations of The Medical Education and Training Enterprise

Prioritize Education and Training in Competencies That Will Produce Value for Patients and the Public

Individual physician competencies help determine overall health system performance. Education and training programs should demonstrate, through rigorous and valid assessment techniques, how they are preparing trainees to:

- Improve the individual patient care experience. Specifically, institutions, faculty and undergraduate and graduate trainees should explicitly and continuously evaluate the care they deliver against the IOM-specified attributes of quality (safety, timeliness, effectiveness, efficiency, equity, patient centeredness);
- Improve the health of defined populations, through use of patient registries, attention to social determinants of health, team-based approaches to primary care that include an explicit focus on appropriate population health indicators; and
- Effectively steward resources in providing care to these populations, by teaching skills that include health risk assessment, statistics, and evidence-based decision making.

Adopt a Contemporary Definition of “Caring and Competent Physician”

Everyone with a stake in medical education and training should adopt a contemporary definition of the *Caring and Competent Physician*. The 21st century physician embodies the following:

- The attributes described in the Physician Charter, which emphasizes compassion, altruism and the physician’s dual responsibility for individual patient welfare and stewardship of resources on behalf of society;
- Engagement with patients as partners, which entails shared decision making and the participation of patients in the design and delivery of their care;
- The skills and competencies defined by the Accreditation Council on Graduate Medical Education (ACGME), which include technical expertise, continuous learning and improvement, systems-based practice (including use of informatics and evidence-based decision supports) and advanced communication skills;
- Competence in inter-professional practice and team-based care;
- The leadership skills and self confidence to act as advocates and drive innovation and improvement in care delivery at the practice and system levels.

These attributes and skills are needed to move health care delivery from a “cottage industry” of independent and autonomous artisans to a “post-industrial” health care system in which medical teams provide care that is based on evidence and are publicly accountable for continuous improvement in clinical performance and outcomes.

Ensure That Every Graduate from Medical School and Residency is a “Caring and Competent Physician”

Accrediting, licensing and certifying bodies need to establish and maintain a measurable floor for physician competency that is “high enough” to assure patient safety and quality of care and

consistently hold education and training programs and their trainees to that standard. Public trust in the profession rests on standardized “quality control” in the medical education and training pipeline.

Manage the Enterprise to Deliver Public Value

Organizations responsible for medical education and training should adopt an “enterprise management” approach to the training mission. This includes engaging with consumers and other stakeholders, locally and regionally, to discern what they need and value from the enterprise; aligning financial and other resources across the organization to optimize that value; and using information and benchmarking to foster continuous self assessment and accountability.

Transparency should be a fundamental principle in the training and institutional setting, with public disclosure of quality and safety information and explicit policies to eliminate or manage potential conflicts of interest.

Value Primary Care

An efficient health care delivery system that is able to assure access for all requires a strong foundation of generalists that currently is lacking. Medical educators should actively promote student interest in the primary care disciplines by emphasizing didactic and clinical training experiences that demonstrate the human rewards and intellectual challenge of primary care in settings that reflect appropriate professional aspirations. The essential components of primary care that enable it to achieve better patient outcomes, decreased costs and greater equity, include reliable first contact care, continuous relationships with patients, comprehensive care services and care coordination services.⁵ Academic health institutions are likely to need to develop broader curricula in order to achieve success in educating and training primary care physicians in how to organize and provide these essential components. Institutional leadership also must ensure that the norms of the informal culture or “hidden curriculum” within the training environment reinforce the appeal, prestige, indeed excitement, of primary care as a specialty choice.

Promote Diversity in Student and Faculty Selection

Academic medicine must do much more to build, develop and nurture the pipeline for underrepresented minorities in order to meet the health care needs of America’s increasingly diverse population. Student admissions and faculty selection processes should also emphasize key values and personal characteristics that are associated with interest in serving economically and geographically disadvantaged populations, such as altruism and compassion, strong interpersonal and collaborative skills, cultural competence, socioeconomic status and rural background. Benefits accrue to all students in educational environments where students and faculty contribute diverse perspectives and life experiences.

Invest in Programs and Faculty Needed to Develop the Caring and Competent Physician

Medical education and training organizations must ensure that their training programs are adequately funded and that their faculty members have the training and resources required to produce physicians with all the attributes of the *Caring and Competent Physician*, including mechanisms to engage patients and families in the education and training process. Institutions should be accountable for demonstrating that public funding intended to support the educational mission is used for that purpose. They must also ensure that faculty have protected time for teaching and supervision; training in state-of-the-art teaching, assessment and feedback techniques; an environment that fosters professionalism and encourages continuous faculty learning and innovation; meaningful peer benchmarks for both themselves and their students; and rewards for excellent educational outcomes.

⁵ Starfield B, Shi L, Macinko J., Contribution of primary care to health systems and health. *Milbank Quarterly*. 2005;83(3):457-502.

Promote Essential Learner Competencies across the Educational Continuum

Educators should select, assess and foster the continuous personal and professional development of *Caring and Competent Physician* using appropriate developmental milestones for each attribute from pre-entry through medical school and post-graduate training. Continuous assessment is required to eliminate the “voltage drops” in emphasis on key skills and attitudes – for example, effective inter-professional collaboration – that occur as students advance through stages of clinical training. Post training, professional certification organizations have a responsibility to ensure that physicians maintain and continue to improve their skills.

II. Medical Education and Training Enterprise Expectations of the Public

Align Physician Payment Policies with Workforce Priorities

Payment policies for clinical practice should be better aligned with public expectations of the 21st century physician workforce. Payment is proxy for what is valued and sends signals that shape the practice and training environments, the goals and expectations of medical students and the clinical priorities of training institutions. Among the key payment reforms essential to reshaping the physician workforce is a closing of the gap between primary care and subspecialty compensation rates. This payment disparity creates powerful incentives for academic medical institutions to focus on developing specialty services and trainees to staff them and also works against efforts to develop more primary care physicians. Equally important are payment policies that explicitly support team-based care and accountability for the health care needs of defined populations. Reorienting the payment system for clinical care delivered in training settings is an essential adjunct to other medical education and training reforms.

Enable Generational Transformation

As a transitional measure, public policies should aggressively support novel pathways to relieve the significant financial burden of student loans for young physicians who commit a substantial portion of their “practice” to socially valuable but un- or under-compensated roles within training institutions. These roles might include, for example, training young colleagues in the sophisticated use of medical informatics, organizational responsibility for bridging public health and medicine, or leading applied research in health system innovations.

Development of 21st Century Practice Settings for Training

Society cannot expect physician to be better than the context in which they train. Learning should take place in delivery systems that demonstrate high performance in care coordination, patient centeredness, quality measurement and improvement techniques and wise stewardship of health care resources. Health system leaders and payers should accelerate development of 21st century clinical models and delivery systems that can serve as training and practice sites for the vanguard of medical students and residents needed to lead the broader transformation of health care.

Patients Recognizing Themselves as Partners

In an academic environment, patients must be active partners in the education and training of new physicians. That partnership entails an appreciation that learning to be a Caring and Competent Physician is a complex, experiential process; one in which patients can play a critical role by asking and answering questions about their clinical conditions, actively engaging in care decisions based on evidence of clinical effectiveness in tandem with individual values and preferences, holding realistic expectations, and providing feedback on their experience to trainees and their clinical supervisors.

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