

# Honoring the “E” in GME

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# Today's Agenda

How did GME get this way?

Does residency education need improving?

What might we do better to honor the “E” in GME?

# A Brief History of GME

**1900** Medical education (if it occurred at all) ended after medical school (2-4 years)

**1910** Flexner report: no mention of GME

## Post-WW I

Growth in knowledge outstripped UGME

Internship quickly became standard for all graduates

**1923** Sufficient internship positions for all USMGs

Residency only for specialized practice or academics



# A Brief History of GME

## Pre-WW II

Further advances in knowledge coupled with demand for specialists led to expansion of residencies

Fierce debate about who should take responsibility for resident education – universities or hospitals

Most universities demurred

But several did start degree-granting GME programs

- 3+ years in a single specialty

- Extensive course work in basic science

- Rigorous examinations

- Original research coupled with a thesis

# A Brief History of GME

By 1941

Most university-based GME programs had disappeared or been absorbed into existing hospital-based programs

Ludmerer (*Time to Heal*)

“Transfer of control of GME from universities to the profession occurred by default rather than by design.”

MGH (1947)

“Undergraduate education is directed by the dean and faculty of Harvard Medical School. The graduate education of the interns and residents is solely a function of the Hospital.”

The dye was cast for a hospital-based,  
department/division controlled  
system of resident education

# A Brief History of GME

Ludmerer (*Time to Heal*)

“GME became hospital-based and professionally regulated rather than university-based and regulated by educators.”

“From the beginning, tension between education and service was evident ...”

# A Brief History of GME

## Post WW II

Huge expansion numbers of residents and of specialties led to fragmentation and reduced cohesion within programs

In-patient focus remained dominant despite shifting disease burden toward ambulatory sites

Pace of hospital care and resident life accelerates

1965 Medicare enacted

# A Brief History of GME

1980+

Sicker patients

Many more of them

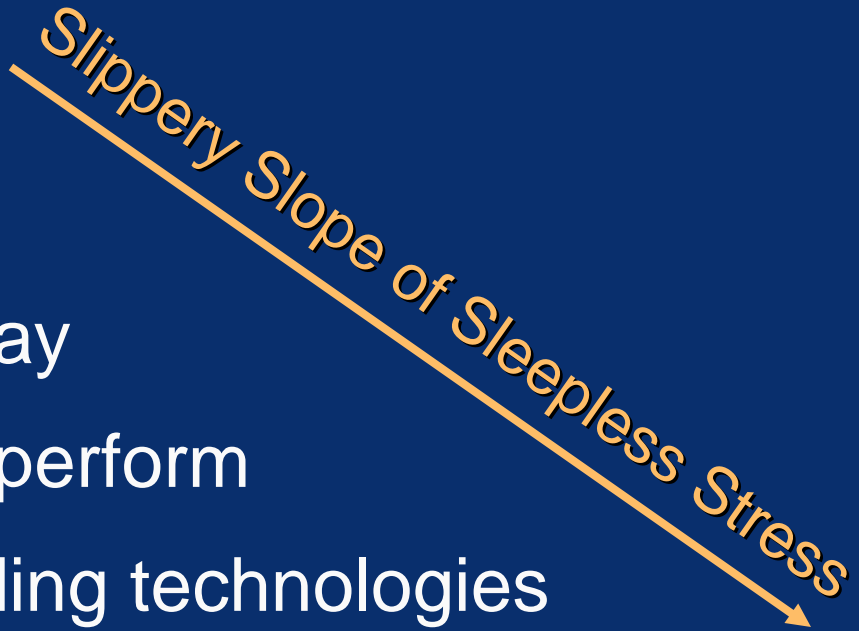
Shorter lengths of stay

More procedures to perform

Vastly more demanding technologies

Service demands trumping educational goals

*Slippery Slope of Sleepless Stress*



No Wonder Residents  
(and the Public)  
Have Raised Questions  
About What We're Up To

Does residency education  
need improving?

Duh!

# What problems did Flexner see in medical school education at the end of the 19th Century?

Apprenticeship model

Lack of uniform standards

Wide variation in educational quality

Wide variation in clinical competence

# The solution was -

A fundamental redesign of undergraduate medical education to meet society's expectations of 20th Century practitioners

# What problems did Flexner see in graduate medical education at the end of the 20th Century?

Apprenticeship model

Lack of uniform standards

Wide variation in educational quality

Wide variation in clinical competence

## Sound familiar?

# The solution is -

A fundamental redesign of  
graduate medical education  
to meet society's expectations  
of 21th Century practitioners

# Design Flaws in Today's GME

Too fragmented

Too hospital focused

Too much service of no or marginal educational value

Too little attention to each resident's needs

- Too much learning is left to chance for all residents
- Too little is done to individualize experiences based on need

Too little time for reading, scholarship, reflection

Learning objectives poorly aligned with known and anticipated practice expectations

Many crosscutting “core” topics are given short shrift

# Crosscutting Core Topics Looking For a Home in GME

- Professionalism
- End-of-life care
- Multiculturalism
- Spirituality
- Population health
- Communication skills
- Clinical Pharmacology
- Medical informatics
- Quality improvement
- Systems thinking
- Leadership
- Teamwork skills

Who owns these topics?

What might we do better  
to honor the “E” in GME?

# 10 Steps Toward Re-asserting the Primacy of “E” in GME

1. Strengthen institutional authority and accountability
2. Reduce (?eliminate) non-educational services
3. Stipulate, explicitly and prospectively, the learning objectives to be achieved before “graduation”
4. Strengthen formative and summative evaluations
5. Tailor curricula to individual needs
6. Establish common educational programs across disciplines to deal with “core” cross-cutting topics

# 10 Steps Toward Re-asserting the Primacy of "E" in GME

7. Require scholarship (e.g., thesis, research)
8. Create clinical settings for resident education that exemplify the highest quality care achievable
9. Convert resident learning environments from crucibles of cynicism to cradles of professionalism
10. Seize 80-duty hour limit, not as a mandate to tinker with a badly flawed GME system, but as an opportunity to transform the system to meet its fundamental obligation to society

# Let me anticipate your first question

Where's the money going to come from?

Answer:

- Much of what needs to be done does not require additional dollars
- The decades-long addiction to “cheap” resident services has blunted our creativity
- If education is truly our core mission, institutional priorities should reflect it
- Every journey begins with a single step