From the Editor

The Most Serious Challenge Facing Academic Medicine’s Institutions

Articles in last month’s issue of the journal describe how the leaders of several medical schools and teaching hospitals responded to important challenges facing their institutions. Those reports provide insight into the scope and complexity of the difficulties academic medicine’s institutions have encountered in recent years. Companion pieces in that issue suggest that academic medical centers are beginning to confront a new and equally important set of challenges: how to develop and implement new approaches for organizing their patient care services. In my editorial, I noted that the need for those new approaches has important implications not only for the ways patients will be cared for in the future, but also for the ways doctors and other health professionals should be educated to care for them. In this editorial, I want to make a few comments about the need for medical education reform.

I believe that reforming medical education is the most serious challenge the leadership of academic medicine’s institutions now faces. I am sure that some readers may think this is an overstatement. I suggest that those readers read two important recent reports—one by the Commonwealth Fund Task Force on Academic Health Centers1 and the other by the Institute of Medicine Committee on the Roles of Academic Health Centers in the 21st Century2—that express concerns about how academic health centers (AHCs) are carrying out their education mission and state clearly the need for medical education reform. The Commonwealth Fund task force report maintains that among the missions of AHCs, “none is more important to the future of the American health care system than the education of physicians.” And the IOM Committee report states that “of the three roles performed by AHCs, the education role is expected to face the most profound changes in coming decades.” It is noteworthy that similar concerns are expressed in reports issued by the Council on Graduate Medical Education3 and the Blue Ridge Academic Health Group.4

To place these reports in proper perspective, it is important to recognize that they are responses to the growing belief that the quality of medical care in this country cannot be raised substantially unless improvements are made in the ways doctors are being educated to care for patients. It is also important to know that in linking improvements in medical care quality to those in medical education, the reports clearly focus attention directly on the need to reform graduate medical education (GME). Why? Because it is during residency training that doctors acquire the knowledge, skills, and attitudes required for the independent practice of medicine. Given this, how should the leadership of academic medicine’s institutions respond?

In a previous editorial, I called on those responsible for GME to review the design and conduct of residency programs to ensure that they are really preparing residents adequately for medical practice. I am convinced that such reviews would show that changes are needed in the ways residents are being made ready for practice, at least in some disciplines. Most important, those reviews would make clear that residents need more opportunities to gain experience caring for patients with the kinds of conditions they will most likely manage when they enter practice. To accomplish this, GME programs will have to be redesigned to ensure that residents spend more time in community-based clinical settings, since these are where the kinds of patients they will care for in the future are currently receiving their care.

But meaningful reform of GME will require more than simply relocating some learning experiences to community-based settings. Instead, GME reform initiatives must strive to improve all of the learning experiences for residents, regardless of where they occur. In this regard, those responsible for GME should pay special attention to the article by Kenny et al. that appears in this month’s issue. The authors point out the importance of apprenticeship for learning medicine. They remind us that physicians have always acquired the “craft knowledge” needed to practice high-quality medicine by participating in the care of patients under the supervision of experienced and skilled clinician teachers. Thus, GME reform initiatives must include efforts to improve the nature of the apprenticeships experienced by residents in training. This means that those responsible for GME must be attentive both to the appropriateness of the settings in which residents will learn medicine and also to the attributes and behaviors of the clinicians who will be role models and teachers in those settings.
So what role should the leaders of academic medicine's institutions play in reforming GME? To begin, they must accept the need to improve the education of doctors and recognize that bold leadership will be needed to make this happen. They must become involved in ensuring that residents will have opportunities to encounter patients who have the appropriate kinds of clinical conditions, even though this will require that residents receive more clinical training in ambulatory care sites and other sites located outside of the domain of the academic medical center. And they must establish institutional processes that reinforce in positive ways the key elements of an effective apprenticeship experience.

In their article, Kenny et al. draw on work done in other fields to develop a conceptual framework for understanding not only how apprenticeship affects learning but also how it can be altered to enhance learning. And they provide an important service by pointing out the need to develop a thoughtful and critical research agenda to elucidate further the elements of the apprenticeship in medicine. The leaders of academic medicine's institutions should support efforts to carry out that agenda. And they also must support programs designed to ensure that the clinical faculty who serve as role models in the clinical learning environment possess the attributes to be effective in the apprenticeship experience. These are ambitious goals, ones that present a major challenge to the leadership of academic medicine's institutions.

In closing, I want to call attention to a report written by Tom Inui, who spent the first half of 2002 at the Association of American Medical Colleges (AAMC) as a Petersdorf Scholar-in-Residence. During that time, he devoted himself to a comprehensive study of medical professionalism. In his report on that topic, A Flag in the Wind: Educating for Professionalism in Medicine, he outlined steps that the leaders of medical schools and teaching hospitals can take to enhance professional behaviors in their institutions, particularly in the settings where clinical education occurs. His recommendations aim to create an institutional culture that clearly values and supports the professional development of the institutions' students and residents. These recommendations are very much in keeping with modern concepts of the importance of transforming organizations so that their cultures support the learning and productivity of those who work in them. For this to occur in medical schools and teaching hospitals, the leadership of the institutions must become directly involved in the transformation process. Tom's recommendations deserve careful attention, since they relate directly to the challenge of improving the apprenticeships experienced by residents.

MICHAEL E. WHITCOMB, MD
Editor

REFERENCES