



PHYSICIAN TRAINING:

PAST

*Public Hospitals and Medical
Schools Shared Mission of
Graduate Medical Education*

& PRESENT

By Gina Rollins



Public hospitals have been closely linked to the training of new physicians since graduate medical education (GME) formally came into existence in the early twentieth century. In a 1910 report, *Medical Education in the United States and Canada*, Abraham Flexner offered a scathing indictment of the state of medical education. Since then, the medical sciences have marched steadily towards more rigorous, structured GME programs and specialized training. As academic medical centers, public hospitals have led the charge.

During the first 75 years of the twentieth century, GME went from a patchwork of one-year internships — undertaken by perhaps no more than half of medical school graduates — to a formal system of training essential to the practice of medicine. The Council on Medical Education published its first guidelines on approved internships in 1919. By World War II, as hospital demand for interns peaked, there were more positions available than interns to fill them.

As GME moved away from catch-as-catch-can internships, residencies in the wards of public and private hospitals became prized training positions despite the meager com-

pensation. Residents often lived in hospitals and were paid only for room and board. Modest salaries, introduced in the 1950s, were raised in the 1960s after enactment of Medicare and Medicaid, which recognized the cost of indirect medical education.

As medical knowledge rapidly expanded from the 1940s on, specialized training and certification became more and more the norm. Before World War II, more than 84 percent of physicians reported being general practitioners, but by 1965, only 37 percent did.

Over the last 30 years, the pace of change

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accelerated even more rapidly and touched most every aspect of GME at public hospitals — from the sites and methods of providing care and the structure of the GME experience to the acuity of patients and the financing of GME. Amidst the hurly burly, however, has been one constant: the steadfast commitment of both medical schools and public hospitals to collaborate in providing excellent medical education and patient care. “Public hospitals and medical education have a broad social mission and are philosophically and inherently natural partners. They’re interlinked,” says Bob Dickler, senior vice president for health care affairs at the Association of American Medical Colleges in Washington, DC.

One important trend has been the expansion in accredited programs, specialties, and subspecialties, Dickler notes. “There are many more accredited programs and many more specialties which are accredited than there were 20 or 30 years ago. The expanded magnitude of GME is remarkable.” In the academic year 2004–2005, there were 8,037 accredited programs with 101,810 residents, up from 6,570 programs and 89,000 residents in 1989, according to data from the Accreditation Council

for Graduate Medical Education (ACGME) in Chicago. The ACGME now recognizes 26 specialties and 84 subspecialties, many of which didn’t exist in 1981, including sleep medicine, sports medicine, endovascular surgical neuro-radiology, and neuromuscular medicine.

The creation of ACGME itself in 1981 was another milestone in medical education, according to Dickler. “The rigor of GME changed substantially when the ACGME was established. When it began refining program requirements and collecting outcomes, GME matured,” he explains.

A New Care Environment

Over the past three decades, technological advances and new payment methodologies have fueled an emphasis on ambulatory care, on high-tech, less invasive interventions, and on shorter hospital stays with sicker patients, all of which impacted both GME and public hospitals.

“Technology is essential to providing an adequate teaching experience and fulfilling our public mission,” says Paul Roth, MD, executive vice president of health sciences at the University of New Mexico and Dean of the University’s School of Medicine. “In recent years we’ve seen a rise in uncompensated care brought about by cutbacks in federal programs and limited state ability to make up the difference, but UNM has done its best to acquire state of the art equipment even while federal and state resources are declining.”

In step with the movement toward ambulatory care, through the 1990s and early 2000s in particular, public hospitals established vast networks of ambulatory care centers and outpatient services, which provided residents and fellows ample learning experiences in those settings. However, the winds of change were even stronger in the inpatient environment, where patient acuity rose and treatment grew ever more complicated. “Twenty-five years ago the house staff worked many longer hours but the intensity of work was less and the complexity of the care environment was a lot less,” explains Scott Barnhart, MD, medical director of Harborview Medical Center in Seattle and associate dean for clinical affairs at the Uni-

BELOW: Bellevue Hospital interns, 1877.

OPPOSITE: Student nurses at the University of Rochester School of Nursing attend to a “patient” in the practice room of their dormitory, 1928.



versity of Washington School of Medicine. “Now the trainees often coordinate care with multiple services; they have to integrate information from more diagnostic tests, and the range of therapeutic options is much broader.”

Financial Challenges

In 2003, in response to overall heavier work loads, the ACGME issued new resident duty hour standards. These requirements, which affected all ACGME-accredited specialties and subspecialties, established an 80-hour weekly work limit (averaged over four weeks); set a 24-hour limit on continuous duty; and required one day in seven free from all educational and patient care obligations (also averaged over four weeks).

This adjustment emphasized the educational experience of house staff over their role as care managers, but it exacerbated the already strained financial circumstances of many public hospitals. The *Balanced Budget Act* of 1997, which capped the Medicare reimbursement formula for indirect medical education payments at 1996 levels, “made it very difficult for hospitals like Harborview that needed to increase the number of residents [in response to the new duty hour standards]. It put a lot of pressure on the hospital, and we had to finance that growth directly out of operations,” says Barnhart. “There’s no teaching hospital in the country that hasn’t undergone stress around the 80-hour work week.”

Financial pressures and the need to operate more efficiently led many public hospitals to change governance structures in the 1980s and 1990s. By 2003, 60 percent of NAPH members were organized either as separate public entities or non-profit corporations. Only 40 percent were operated directly by state or local governments. The new governance “permitted those institutions to run in more business-like ways, to be more responsive to their customer base and in many cases more dependent on private patients. This led to the belief by traditional public hospital funders that they could decrease support [for the public hospital],” says Dickler. “As a result, a number of public hospitals evolved into very different institutions, and how they approach



medical education changed. That’s neither good nor bad; just reality.”

The changed governance and financial circumstances accelerated efforts begun with the advent of diagnostic related groups (DRGs) in 1983 to hasten patient throughput and boost the quality of care while streamlining the use of resources. This led to greater use of evidence-based medicine in GME, in guiding patient care, and in making investments in technology, according to Barnhart.

As medical schools and public hospitals contemplate the next quarter century, both face numerous challenges but remain united by a shared mission to educate succeeding generations of physicians. “When I came here 25 years ago, we loved Harborview, and people working and training here today love it,” observes Barnhart. “Our goal is to make the best training and care environment possible.”

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