

Graduate Medical Education: The IOM Made a Good Start But More Is Needed

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The Society of General Internal Medicine (SGIM) welcomes the release of the Institute of Medicine (IOM)'s long-anticipated report on how to reform graduate medical education (GME) funding. We applaud the recommendations and look forward to working with other professional groups and education leaders in implementing them. We believe, however, that full GME reform will involve more changes, including recommendations recently made by SGIM.

The IOM report was requested by a bipartisan group of senators concerned that the GME system is "failing to match medical training with our medical needs on a national level." They called for a redesign of health care workforce education and training so as to improve access to and delivery of services. That seems simple, but getting there requires overcoming multiple challenges. The fundamental dilemma confronting policymakers? Meeting the health care needs of the US population—including 32 million Americans newly eligible for coverage through the Affordable Care Act—under a constrained federal budget.

The United States GME system is the envy of the world. GME has grown to a multi-billion dollar enterprise, supported in large part by Medicare, which provides nearly \$10 billion of the \$15 billion the federal government spends annually on preparing new physicians to become high-quality clinicians.

SGIM believes that the current GME system is not well aligned with the nation's health care needs. Most important, GME is falling far short of restoring a robust, sustainable primary care infrastructure—the cornerstone of any high-performing health

care delivery system. If recent trends continue, only 20.9% of last year's graduating medical students will practice primary care after completing residency training. Thus, the gap between generalist supply and demand will continue to widen.

SGIM agrees with IOM's overall goals and recommendations for improving GME, particularly as they relate to the shortage of primary care physicians and efforts to improve the transparency and accountability of the system. IOM's report, however, should not be considered the final word on this topic. Instead, it creates the opportunity for broader collaboration among stakeholder organizations as well as federal policymakers and Congress and serves as an important stepping-stone for addressing other facets of GME that fall outside the scope of IOM's report.

In "Addressing the Nation's Physician Workforce Needs," published earlier this year in *JGIM* (PMID: 24733299), a panel of SGIM experts set out six recommendations that reflect our organizational goals to prepare a physician workforce capable of providing high-quality, high-value, population-based and patient-centered health care that is aligned with the changing needs of our nation's health care delivery system. Those recommendations are:

1. *Congress should fully fund the National Health Care Workforce Commission.* Decisions affecting the allocation of GME positions must be based on data from unbiased sources that assess current and accurately predict future health care needs.
2. *All entities that pay for medical care should contribute to GME funding, and funding levels*

should reflect the true cost of training a physician workforce aligned with national needs. Since all who receive and pay for medical care share the benefits of a well-trained physician workforce, all payers—not only the Centers for Medicare and Medicaid Services—should contribute to the cost of medical training.

3. *In an era of scarce resources, GME dollars must be allocated transparently and exclusively for resident training and related costs.* The Health and Human Services secretary should immediately take steps to require institutions to report their GME costs and the total amount of direct and indirect funds received, including the number of residents and fellows supported with GME funds by specialty and training location.
4. *GME-funded training programs must demonstrate that their graduates have the competencies required to provide optimal, cost-effective care, including training in evidence-based medicine, team-based care, and care coordination.*
5. *The GME system should provide incentives to align the practice patterns of graduates with national and regional workforce needs.* Health care systems built on a robust primary care workforce produce better outcomes at lower costs than systems without a primary care base. Direct accountability by GME institutions—linking the receipt of GME dollars with workforce outcomes—is an important step to restoring a

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robust and sustainable primary care base.

6. *Funding should be available to foster innovation.* The federal government should support and test innovative education and training models that allow GME to more readily adapt to practice in the 21st century.

It is tempting to argue that more GME funding is the answer, but more money would not overcome

the maldistribution of physicians by specialty or geography. More money would neither sufficiently prepare graduates to provide cost-effective, evidence-based care nor provide them with meaningful experiences in patient safety, quality improvement, chronic disease management, care of the elderly, and coordination of complex care in inter-professional teams.

Aligning GME with the nation's health care needs will not be an easy

task. It will require broad changes at multiple levels spread over several years. SGIM will continue to engage policymakers, teachers of medicine, patients, and colleagues in an effort to strengthen our system of GME. Too much is at stake to miss the opportunity to reform GME.

Editor's Note: The above is an abridged version of SGIM's public response to the IOM report.

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