INTRODUCTION

This position paper examines the need for graduate medical education (GME) and the benefits it provides. It outlines the general positions of the American College of Physicians on a number of issues related to the financing of GME and discusses important factors that should be considered in developing national policy. The first two positions are fundamental: (1) graduate medical education is linked with patient care and is practically inseparable from patient care; and (2) graduate medical education and the environment in which it takes place -- generally, the teaching hospital -- serve the public good. The positions that follow maintain that continuation of some public financial support of GME is necessary, and that private support through payments for patient care services is also justified.

The College believes that the complexity of modern medical care necessitates that all new physicians complete residency training in an accredited GME training program. The issue of financing GME must be addressed in a comprehensive national health manpower policy in which the supply and specialty distribution of physicians are coordinated with national, state, and local health manpower needs. Financing of GME must also be considered in formulating public policy regarding physician reimbursement. Opportunities should continue to exist for the training of limited numbers of foreign medical graduates (FMGs) who will return to their country of origin upon completion of training.

POSITION

1. Graduate medical education is fundamentally linked with patient care and for practical purposes is inseparable from patient care. Therefore, patient care revenues should continue to be an appropriate source of funding for GME.

RATIONALE

Graduate medical education (GME) refers to the advanced education and training required of medical school graduates to become fully prepared to provide medical care independently. It involves a period of residency training lasting three to seven years in which physicians are directly supervised in their learning while they assume progressively greater responsibility for patient care. GME includes clinical fellowship training in which physicians who have completed a residency program obtain advanced subspecialty training.
GME is principally comprised of two components: expansion of the knowledge base gained in undergraduate medical education and development of the clinical experience base started in medical school. In large part, education in these two components is gained through observation, performance, and the teaching of others. The first two of these activities represent the medical service itself; the third represents a refinement of the service. The fact that all three take place in the educational setting, under the supervision of clinical faculty, endow them all with an educational aspect in addition to their inherent patient care aspect. Thus, because the setting of the service involves both patient care and education, the educational and care components are not readily separable. In addition, patient care is not merely a service performed by the physicians-in-training, but is the service as supervised by clinical faculty.

Patient care revenues and general operating funds provide almost 70% of funds nationwide for resident housestaff stipends and fringe benefits. They provide approximately 56% of the funds available for clinical fellows at major teaching hospitals. Approximately 17% of funds for residents and 13% of funds for clinical fellows are provided by the Veterans' Administration.

Dependence on patient care revenues for the support of housestaff varies widely by type of hospital ownership. Some hospitals receive financial support from state and local governments for housestaff expenses. These earmarked and general appropriations average 13% of housestaff stipends and fringe benefits for university hospitals, 23% for state hospitals and about 11% for municipal hospitals. However, many not-for-profit hospitals rely solely upon patient care revenues to pay for their housestaff (1).

Because GME is inescapably intertwined with the provision of patient care, it is appropriate that patient care revenues continue to be the major source of funding for housestaff. Curtailment of patient care revenues for funding housestaff would have a devastating effect on the viability of many residency training programs. Yet, some recent proposals concerning hospital reimbursement under Medicare could reduce such revenues substantially.

Prior to 1983, Medicare paid for all inpatient hospital services, including GME, on a retrospective, reasonable cost basis. With the implementation of a prospective payment system (PPS) in which reimbursement for all hospitals is based on predetermined rates for each diagnosis related group (DRG), the problem has surfaced as to how to pay appropriately for services at teaching hospitals. Higher costs of teaching hospitals due to the additional services and functions they perform would not be compensated under a purely DRG based prospective payment system. Congress recognized the complexity of GME financing and the difficulty of paying appropriately without adequate financial data. The Department of Health and Human Services was directed, therefore, to conduct a study of the issue and to prepare recommendations to Congress for handling GME under PPS.
In the interim, Congress provided that teaching hospitals could continue to bill Medicare for its share of the direct costs of medical education on a retrospective, reasonable cost basis. Further, recognizing the difficulty of accounting for differences in severity of illness, case mix differences, and higher overhead costs associated with teaching programs, Congress doubled the limits established under TEFRA (PL 97-248) to reimburse teaching hospitals for indirect educational costs. Teaching hospitals now are allowed additional payments equal to 11.59% for each 0.1 residents per hospital bed. This formula, in actuality, represents a proxy for the additional costs of teaching hospitals as well as a payment for their indirect educational costs.

The existing method of a "pass through" for direct educational costs and a proxy for indirect educational costs based on number of residents per bed provides few incentives for economy or efficiency in teaching programs. It compensates all teaching hospitals, both inner city and suburban, for educational costs, indigent care, and the resource burden of greater severity of illness regardless of the extent these services add to the costs of operating the hospital. While we maintain that it is impossible to separate the graduate medical education component from patient care services and that payments for patient care at teaching hospitals should reflect appropriately the cost of services rendered, we recognize that better accounting methods for attributing costs must be found, and more appropriate means of financing different kinds of costs must be developed. Still, recognition of the additional cost of GME should be reflected in payments for patient care services at teaching hospitals.

POSITION

2. Graduate medical education serves the public good, and therefore should receive public financial support.

RATIONALE

Although there is no proof of a linear relationship between length of medical training and positive health outcomes for patients, the absence of such proof should not suggest that GME lacks value. There are many things to suggest that GME is highly valuable. For example, it is clear that both the medical profession and the public place a high value on the significance of GME. The profession recognizes the breadth and complexity of knowledge and experience necessary for medical practice, and through a plethora of accrediting and credentialing mechanisms, attempts to assure these qualifications. The profession continues to seek the improvement of systems to accredit training programs, to monitor trainees' progress, and to provide credentials to physicians who meet rigorous professional standards of knowledge and performance. All hospitals, and indeed all organizations that utilize physicians to deliver medical care, depend upon these mechanisms for assurance that physicians are fully qualified.
Patients and third-party payers, through their activities and choices in the medical market, attribute greater value to highly trained practitioners. Professional responsibilities for accreditation and credentialing are, to a large extent, validated by the preferences of patients and their choices of well-trained practitioners. Federal agencies such as the VA and other employers of physicians, including health maintenance organizations, also recognize the added value of advanced training and pay higher salaries to board certified physicians.

Second, the public benefits directly from services provided by individuals in GME training programs. Those services encompass care for two groups that are disproportionately served by the teaching hospital: severely ill patients and indigent patients. Severely ill patients require a higher intensity of medical services and a more readily available physician. Physicians-in-training provide both highly intensive involvement with patients and round-the-clock, on-site, accessibility. The indigent population is a disadvantaged group whose access to care is enhanced by the educational programs of teaching hospitals. Housestaff of teaching hospitals provide primary health care to large numbers of this population in areas where there is a lack of access or a lack of providers.

Third, the setting within which GME takes place, the teaching hospital, is valued as a national resource. The teaching hospital, in providing both clinical care and GME, brings together a constellation of medical care resources and personnel that fosters a unique environment for innovation. The teaching hospital promotes innovation not only in the development and dissemination of medical technologies (drugs, devices, and procedures), but also in important medical concepts (methods of diagnosis and treatment; the process of medical decision-making; the importance of social, legal, ethical, and economic considerations) along with the pursuit of academic and professional excellence. The teaching hospital is the site where most of the nation's clinical research takes place, most of its drugs and medical devices are tested, and most of its medical and surgical procedures are conceived, developed, and refined. Additionally, the teaching hospital is the locus from which these innovations, critically important to the improvement of patient care, are disseminated. The development of these new technologies and medical care approaches is expensive, particularly before economies of scale and experience in using them enable their more efficient production. The teaching hospital provides an intellectual environment that encourages necessary pursuit of medical knowledge.

POSITION

3. The complexity of modern medical care necessitates that all graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) should complete residency training in an approved graduate medical education program prior to engaging in independent medical practice. Adequate financial support must be available to maintain residency training programs to fulfill this educational requirement.
RATIONALE

Because of the importance we as individuals and as a society attach to our health, it is essential to ensure that those who furnish medical care are highly qualified. Multiple mechanisms exist to provide this protection. The Liaison Committee on Medical Education (LCME) establishes and maintains standards of quality for undergraduate medical schools. LCME standards are designed to ensure that all medical school graduates are fully prepared in the basic medical sciences and have had sufficient exposure in the clinical sciences to pursue a program of GME. All undergraduate medical school programs that grant the degree of doctor of medicine in the United States and Canada are accredited by the LCME.

The Accreditation Council for Graduate Medical Education (ACGME) provides similar assurances that GME programs meet certain standards of quality. There are 1,530 institutions and agencies that sponsor 4,759 residency programs approved by the ACGME. To obtain accreditation, each program must meet "General Requirements" that are prerequisites for all programs regardless of specialty. They must also meet "Special Requirements" that provide standards concerning curriculum content, required resources and personnel, duration of training and other requirements specific to each specialty. Each specialty has a Residency Review Committee (RRC) that evaluates all programs to determine if they meet the established "General" and "Special" requirements. Most fully accredited programs are reviewed every five years; those with provisional or probationary status are re-evaluated at shorter intervals.

This accreditation process ensures that the care received by patients from physicians-in-training is adequately supervised and is of high quality, and among other things, that patients are not exposed to additional risk because of the training environment. Indeed, patients benefit by receiving care that involves an expert medical team familiar with the latest developments in medical science at facilities that are staffed and equipped to provide a full range of medical services.

The United States historically has attempted to assure a minimum level of competence of physician practitioners through state licensure in addition to accreditation of training programs. However, most states require graduates of U.S. medical schools to complete only one year of graduate training to qualify to take a medical licensure examination. Only two states (Connecticut and New Hampshire) require two years of graduate training; eight states have no minimum GME requirement (Indiana, Louisiana, Massachusetts, Missouri, New York, Ohio, Tennessee, and Texas) (2).

The College believes that the breadth and complexity of modern medical practice now necessitate that the minimum level of required GME be increased and that the completion of an approved residency program be a prerequisite for licensure for fully independent clinical practice. The commitment of the individual practitioner to this degree of graduate medical education would thereby more nearly equate with the profession's
assertion that graduate medical education is in the public interest. The medical profession and medical students have in general recognized the need for residency training. The Liaison Committee on Medical Education (LCME) has also stated that it considers the undergraduate period of medical education insufficient to prepare a student for independent practice without additional graduate training.

The American College of Physicians believes that graduate medical education is necessary for the provision of care of appropriate quality and, therefore, we support a requirement that all practicing physicians be adequately trained in accredited residencies.

POSITION

4. The issue of the funding of graduate medical education cannot be disassociated from a discussion of national health manpower policy. National health needs should be addressed in a comprehensive manner involving long-range planning and coordination of the supply and specialty distribution of medical manpower. Consequently, national health manpower policy must address the aggregate size of undergraduate medical school enrollments, the number of graduate medical education training positions, as well as the number of foreign medical school graduates permitted entry into the United States.

RATIONALE

Arguments against the continued funding of GME from public funds are based, in part, on the widely held perception that the United States will soon have a surplus of physicians. Such arguments typically assert that the competitive marketplace will adequately ensure an appropriate balance between the supply and demand for physician personnel.

We have serious doubts that the economic forces of the competitive marketplace will produce the appropriate numbers or the specialty and geographic distribution of physicians that best serve the nation's medical manpower needs. In an increasingly competitive environment, there are pressures for hospitals to curtail programs that do not generate sufficient revenue and to expand those that are revenue producing irrespective of the impact on the availability of needed medical services. Competition in the medical marketplace does not assure that all people in need of medical care will have access to an appropriately trained physician or to appropriate medical services.

In the extreme case, withdrawal of public funding of GME would limit opportunities for a medical career for those unable to obtain their own financing. Opportunities would thus be restricted for minority and financially disadvantaged groups, as well as for most students from middle-income families. We believe that opportunities for medical careers should remain available to physicians from all socioeconomic backgrounds regardless of ability to pay. Rather than terminating funding of GME, a more appropriate response to the impending numerical surplus should be to develop a comprehensive national health manpower
policy in which the supply of health professionals is coordinated with national health manpower needs.

All appropriate elements of society, including teaching hospitals, federal and state governments, and the Veterans' Administration, should be involved in addressing the overriding issue of the appropriate total numbers and geographic distribution of physicians, including the appropriate mix of specialties and subspecialties. We believe that decision-making on this issue should be performed neither solely by government nor by the medical profession, but should include both those elements as well as others. A national body should be convened to propose policy actions based on data derived from studies of national manpower needs.

The lengthy educational period involved in preparing today's physicians (approximately 10-15 years after high school) necessitates that any national health manpower policy involve long-range planning of national health care needs and health manpower supply. Such planning should encompass not only planning for physicians, but for all health care professionals. National policy should recognize an obligation to maintain opportunities for those students currently enrolled in accredited medical schools to complete their medical training. Consequently, adjustments in physician supply should link the number of GME training positions to the number of students graduating from approved medical schools.

As a beginning step, we recommend that the total number of positions for each year of residency be limited to the total annual number of graduates of schools approved by the LCME and the American Osteopathic Association (AOA), since those numbers (roughly 17,000 per year) appear to ensure at least an adequate supply of physicians. Consideration might be given to increasing these numbers slightly to permit sufficient flexibility for physicians to obtain residencies in their chosen field of specialty. Future adjustments in physician manpower supply should be implemented in accordance with a long-term national health manpower policy by funding mechanisms creating incentives or disincentives to influence undergraduate medical school enrollments.

We believe that this nation should maintain its preeminence in international medical education, and should not abandon its role as a trainer in the medical sciences of physicians from foreign countries. Consequently, we believe that there should be sufficient residency training positions in the United States to accommodate limited numbers of foreign medical graduates. Opportunities for GME in the United States for foreign physicians should exist primarily for those who will return to their country of origin upon completion of training.

We strongly recommend that attention be given to determining the appropriate number of FMG's permitted and that consideration be given to developing alternative sources of financing for their training. We urge also that serious consideration be given to whether or not publicly supported GME training should be available to U.S. citizens who obtain medical training abroad at unaccredited medical schools.
We believe most strongly that physician manpower issues are of national consequence, that the market for physicians is a national market, and that the degree of variation among the states in numbers and types of medical schools, teaching hospitals, and resident mix is such that issues of physician manpower should not be left for decision solely at the state level. However, because of varying state need, neither should all decisions of manpower policy and implementation of that policy be made solely at the federal level. We, therefore, urge development of a national health manpower policy with appropriate state and local input and flexibility.

POSITION

5. The funding of graduate medical education must be a part of discussion of issues of physician reimbursement.

RATIONALE

It is likely that incentives and disincentives built into the present system of third party reimbursement are factors that figure in specialty and subspecialty choice by physicians as they begin graduate medical education. Thus, changes in the system of reimbursement are likely to lead to changes in specialty and subspecialty choice. Likewise, it is probable that changes in the support for GME, to the extent that those changes place a greater financial burden on the physician-in-training, also may lead to changes in subspecialty and specialty choice. Revenues from patient care services also could influence the availability of residency training positions.

Consequently, we urge that the physician reimbursement system be re-examined and that a system be developed that minimizes the effects of finances on medical decision-making. The reimbursement system should not dictate either GME training sites nor the medical education curricula. Currently, inpatient GME is funded by Medicare Part A and other third-party payers, but training in the outpatient setting receives only limited funding. Training in outpatient settings usually depends on either special grants or upon funds from inpatient programs. On rare occasions, limited funds are available from faculty patient care revenues. We believe that medical educators should be able to determine the appropriate sites of GME training, and that the reimbursement system should not unduly influence these decisions.

We as a professional medical society and as individual physicians should not allow economic incentives or disincentives to improperly affect the medical decision-making process. Neither should we countenance a reimbursement system that allows economic incentives to influence inappropriately the specialty distribution of physicians. We, therefore, urge that a changed structure of funding of GME not ignore the effect of the reimbursement system on physician career choice and thus specialty mix.
NOTES
