IOM Releases Report on Graduate Medical Education

On July 29 the Institute of Medicine (IOM) released a report on graduate medical education (GME) (1). This is the residency training that doctors complete after finishing medical school. This training is funded by about $15 billion annually from the Federal government with most of the monies coming from the Center for Medicare and Medicaid Services (CMS). The report calls for an end to providing the money directly to the teaching hospitals and to dramatically alter the way the funds are paid. Instead payments would be made to community clinics phased in over about 10 years. To administer the program, the report recommends the formation of two committees: 1. A GME Policy Council in the Office of the Secretary of the U.S. Department of Health; and 2. A GME Center within the Centers for Medicare & Medicaid Services to manage the operational aspects of GME CMS funding. The later committee would administer two funds: 1. A GME Operational Fund to distribute ongoing support for residency training positions that are currently approved and funded; and 2. A GME Transformation Fund to finance initiatives to develop and evaluate innovative GME programs, to determine and validate appropriate GME performance measures, to pilot alternative GME payment methods, and to award new Medicare-funded GME training positions in priority disciplines and geographic areas.

If adopted, the plan would end decades of attempts by CMS to coerce medical school graduates into primary care, especially in rural, underserved areas. By controlling funding for GME training, CMS would be able to dictate how physician training. Negative reaction was expected and swift from the American Hospital Association, the American Medical Association and the American Council on Graduate Medical Education, whose members would lose CMS money (2-4). Also expected, the proposal was supported by the American Academy of Family Physicians whose members who would gain under the proposal (5).

The IOM committee has a point. Despite a growing public investment in GME, there are persistent problems with uneven geographic distribution of physicians, too many specialists, not enough primary care providers, and a lack of cultural diversity in the physician workforce. Furthermore, according to the report "a variety of surveys indicate that recently trained physicians in some specialties cannot perform simple procedures often required in office-based practice."

However, can a committee formed by CMS be expected to improve the health of America? Based on the composition of the committee and their past performance we think not. First, the committee was co-chaired by Don Berwick who was head of the Institute for Healthcare Improvement (IHI), CMS Administrator and presently a candidate for Massachusetts governor (6). During Berwick's tenure, the IHI proposed a number of non- or weakly evidence-based metrics. Many of these have been found to make no impact on patient-centered outcomes such as mortality, length of stay, readmission rates, morbidity, etc. (7). An example was the 18 month 100,000 Lives Campaign which according to Berwick prevented 122,300 avoidable deaths. However, the methodology, incomplete data and sloppy estimation of the number of deaths
makes Berwick's claim dubious. Furthermore, when the campaign was expanded to the 5,000,000 Lives Campaign the "results" could not be reproduced. Also during Berwick's tenure, IHI prematurely championed tight control of blood sugar in the ICU, an intervention which resulted in a 14% increase in ICU mortality when properly studied (8). Undaunted, Berwick put many of these same meaningless metrics in place when he became administrator of CMS. One of these metrics, readmission rates, has been associated with a higher mortality (9). Now Berwick is running for Massachusetts governor. One wonders how politics might have affected the report.

Other members of the committee include the committee co-chair, Gail Wilensky, who was administrator of HCFA (the precursor of CMS), nurses, physician assistants, economists, a representative from industry and a number of academics. Missing were members of the large community of practicing physicians. It seems the IOM committee was assembled to produce a political rather than an evidence-based answer of how to solve patient care disparities. To paraphrase a well-known quote, the first casualty of politics is usually the truth. It seems likely that the proposed GME Center within CMS would have a similar composition to Berwick's present IOM committee and would likely offer political rhetoric rather than meaningful reform to GME. Similarly to those championed by Berwick at IHI and later CMS, we suspect that a series of meaningless metrics would be required that would do nothing other than add a paper burden to a medical system already drowning in paperwork. By removing local control, CMS will likely ignore local strengths. For example, the University of Colorado has an extremely strong pulmonary and critical care division. Although America needs this physician expertise, especially critical care, it seems likely that CMS might move these residency slots to family practice or general medicine. We believe that local control with appropriate incentives, is more likely to solve these problems than a centralized bureaucracy in Washington.

Lastly, a word about the report's claim graduates lack the skills to perform basic procedures. Our observations are similar and we are inclined to accept the claim. However, we point out that it was decisions of committees such as those proposed that required attending physicians to perform procedures in order to be reimbursed and that residents have fewer opportunities to perform procedures due to work hour restrictions. The committee's implication that somehow physician trainers are to blame seems quite disingenuous. Not identified in the report but crucial to physician development is developing skills to critically evaluate medical literature, rather than blindly follow the guidelines proposed by CMS, IHI or others of a similar ilk.

The proposals in the IOM report are a bad idea from a committee whose head has been rife with bad ideas. The committee's report is not the "New Flexner Report" but will be the coffin nail in the death of quality, caring physicians if adopted.

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References


