

Medical Education after the Flexner Report

TO THE EDITOR: Cooke and colleagues (Sept. 28 issue)¹ trace the changes in medical education that have occurred since the Flexner report was issued a century ago and outline the current challenges. A recent international Web-based survey of 806 of the 2200 members of the Association for Medical Education in Europe (37%) focused on the perceived needs of medical educators from 76 countries. The United Kingdom and the United States had the highest representation among the responses (24% and 10%, respectively). The main challenges in medical education identified by the survey respondents were lack of academic recognition (40%), funding (36%), faculty development (24%), time for medical education issues (22%), and institutional support (21%). In addition, development in medical education research methods (63%), computer-based training (46%), and course and curriculum evaluation (40%) were identified as high-priority needs. We think Flexner would agree that in the current international community of practice, the choices we make about the distribution of resources for the development of teachers are fundamental to the future of medical education and the health of society.

Sören Huwendiek, M.D.

University Children's Hospital Heidelberg
69120 Heidelberg, Germany
soeren.huwendiek@med.uni-heidelberg.de

Stewart Mennin, Ph.D.

University of New Mexico School of Medicine
Albuquerque, NM 87131

Christoph Nikendei, M.D.

University of Heidelberg Medical Hospital
69120 Heidelberg, Germany

1. Cooke M, Irby DM, Sullivan W, Ludmerer KM. American medical education 100 years after the Flexner report. *N Engl J Med* 2006;355:1339-44.

TO THE EDITOR: Cooke and colleagues provide a tribute to Flexner and an informative history of North American medical education. The factors that stress our current system culminate in the question "Who will do the teaching?" and the recognition that "a final problem is the financing of medical education."

Persons capable of teaching are compensated by means of several mechanisms. Laboratory

investigators (and a few clinicians) compete for grants, predominantly from a branch of the federal government. Clinicians bill insurance providers (including the government). Clinician-investigators collect funds for participation in trials that are sponsored by pharmaceutical companies, cooperative groups, or the government.

Despite the creation of "clinician-educator" tracks at some centers and the stray grant available for educational activity, there is no consistent, realistic mechanism through which teachers can expect meaningful material compensation. Until such a mechanism is created, we will continue to have a crumbs-off-the-table, trickle-down system for financing education; intensified curriculum revision will not correct this situation, nor will reliance on the magnanimity of medical school deans. The "will to change" relies on a will to pay; will anyone step forth?

Jonathan D. Schwartz, M.D.

Imclone Systems
Branchburg, NJ 08876
jonathan.schwartz@imclone.com

TO THE EDITOR: Cooke et al. succinctly summarize the challenges involved in training physicians. However, they do not discuss the elephant in the room. Physician assistants have a 2-year postbachelor education program, as compared with a 7-year postbachelor program for internists, pediatricians, and family practice specialists. Physician assistants receive much of their training "on the job," having moved on with their lives and minimized their educational debt. In many practice settings, physician assistants and their nursing counterparts, nurse practitioners, function highly autonomously. Two years or 7 years — what can allopathic and osteopathic medical education learn from this?

L. Allen Kindman, M.D.

Cardiovascular Care of Northern Carolina
Oxford, NC 27565
lakindman@cc-nc.com

TO THE EDITOR: The overview of medical education by Cooke et al. provides considerable insight regarding the inherent difficulties in changing a complex and evolving medical education cur-

riculum. The article does not mention, however, a critically important force that has powerful effects on curricular change: external regulation. The professional regulatory organizations (the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the United States Medical Licensing Examination, and the American Board of Medical Specialties) promulgate standards that directly affect educational practices, such as the 80-hour residency workweek and the Step 2 clinical skills examination of the United States Medical Licensing Examination. Although each regulatory organization is doing an exemplary job within its specific sphere, I am concerned that there is no overarching harmonization of their efforts. As a result, the medical education continuum tends to be compartmentalized and somewhat fragmented. It has been pointed out that “the continuing multiplicity of bodies and responsibilities prevents optimal, systemwide approaches.”¹ I think that in our review of the status of medical education, we must take into consideration the “strong forces” of regulation and how they can best be harnessed collectively to implement the needed changes in medical education.

Steven A. Wartman, M.D., Ph.D.

Association of Academic Health Centers
Washington, DC 20036
swartman@acadhlthctrs.org

1. Blue Ridge Academic Health Group. Reforming medical education: urgent priority for the academic health center in the new century. Report 7. Atlanta: Emory University, May 2003.

THE AUTHORS REPLY: Huwendiek et al. and Schwartz point out that medical teachers lack resources in both the United States and Europe; we could not agree more. Like Huwendiek et al., American medical educators have commented on the denigration of clinician-teachers¹ and uneven professional development for the teaching role.² We concur entirely with Schwartz that teaching, the original mission of medical schools, lacks a reliable funding stream because of the diversion of revenue intended for education to other missions.

Kindman notes that physician assistants receive a dramatically shorter education than physicians, even those in generalist disciplines. The

length of physician training, the associated debt burden, and perhaps the undesirable shifts in career choices have led to proposals for shortened training in both internal medicine³ and general surgery.⁴ Although physician assistants provide excellent care, they function as a member of a physician assistant–physician team⁵ and thus have a role that is quite distinct from that of the physician. We concur with Kindman’s implied question: Might medical training be made substantially more efficient? One of the sources of inefficiency in medical training has been the compartmentalization of medical education into discrete stages with abrupt and often difficult transitions from one stage to the next. This curricular segmentation has been reinforced by the multiplicity of regulatory organizations, each with its own jurisdiction. Until recently, the regulatory organizations described ideal educational experiences in terms of process measures — primarily, how long the learner spent in one setting or another, rather than the outcomes for the learner. Fortunately, that is beginning to change. We have no doubt that Abraham Flexner would endorse the vision of our correspondents: a thoughtful educational program, overseen by regulatory organizations working cooperatively to provide coherent oversight across the curriculum, in which the experiences of the students and residents would be of high educational value. The linchpin in the system is a cadre of faculty with the motivation and skill to teach well and the salary support to do so.

Molly Cooke, M.D.

David M. Irby, Ph.D.

University of California, San Francisco
San Francisco, CA 94143

Kenneth Ludmerer, M.D.

Washington University
St. Louis, MO 63130

1. Levinson W, Rubenstein A. Integrating clinician-educators into academic medical centers: challenges and potential solutions. *Acad Med* 2000;75:906-12.

2. Houston TK, Ferenchick GS, Clark JM, et al. Faculty development needs. *J Gen Intern Med* 2004;19:375-9.

3. Goldman L. Modernizing the paths to certification in internal medicine and its subspecialties. *Am J Med* 2004;117:133-6.

4. Kavic SM. Surgical training should be shortened for specialists. *Curr Surg* 2003;60:475-6.

5. Competencies for the physician assistant profession. *JAAPA* 2005;18:16-8.