Are Physicians Commodities? The Perspective of a Group of *JGME* Editors

Gail M. Sullivan, MD, MPH
Jeffrey S. Berger, MD, MBA
Lalena M. Yarris, MD, MCR
Anthony R. Artino Jr, PhD
Deborah Simpson, PhD

This issue of the *Journal of Graduate Medical Education* (*JGME*) includes "A Call to Action,"[1] an introduction to the Clinical Learning Environment Review (CLER) National Report of Findings 2018, written from the perspective of health care executives with expertise in health care finance and administration, who are also informed by years of service to the Accreditation Council for Graduate Medical Education (ACGME) Board of Directors. Although the target audience of this call to action is health care executives, the graduate medical education (GME) leaders, faculty, and researchers who are the typical readers of *JGME* will also find this perspective thought provoking and relevant. The ACGME's CLER program seeks to improve the clinical learning environment and educational experiences of residents and fellows, with a focus on 6 areas: patient safety, health care quality, transitions, supervision, well-being, and professionalism. Clearly, success in these areas will require effective collaboration among the sponsoring organization's health care executives, clinical departments, and educational leaders.

However, as the article's primary audience is health care leaders, it may benefit from some translation efforts by the editors of *JGME*. For example, an overarching focus of "A Call to Action" is how to leverage CLER, through use of residents and fellows as "assets,"[1] to achieve hospital goals. From their vantage point of steering the larger institutional enterprise, the authors appear to view the hospital as the "business" that employs a variety of assets to achieve goals for customers. In contrast, physicians view the hospital primarily as a space to foster interactions between sick patients, physicians, and other health professionals. In addition, physicians do not typically view themselves as commodities—and we heartily agree. Health care differs from other businesses in so many ways—most importantly, the trust required between patient and clinician, significant quality-of-life consequences of many decisions, and duty of physicians to place their patient's welfare at or above their own. Those in health care must also be continuously concerned with issues of honesty, integrity, ethics, and mistreatment, which were highlighted in the recent CLER professionalism report,[2] yet remain largely unaddressed in the "Call to Action."

In addition to having a different conceptual framework regarding the role of GME within hospitals, *JGME* readers may view the CLER program through a specific educational lens. Take the topic of teamwork, for example. The authors suggest, "clinicians need training on how to be strong team members,"[1] rather than *team leaders*. While team member training is an important focus of undergraduate medical education, GME faculty are challenged by how to ensure that residents and fellows achieve team leadership competencies in the setting of curricular overload, reduced work hours, and heightened administrative and documentation expectations. The difference between member and leader is highly relevant to those in the GME world.

Every hospital that supports GME currently gets millions of dollars in Indirect Medicare Expense (IME) to support environments that are conducive to training programs. These IME funds are aimed at supporting hospitals to maintain complex case mixes, caring for underinsured patients, and delivering advanced service lines, such as trauma or transplantation. The IME is derived as an add-on charge for diagnosis-related groups and modified by the ratio of full-time equivalent residents to hospital beds. The IME funds represent 70% of the total GME Medicare expenditure, or roughly $8 billion to hospitals annually. The IME funds are distinct from the $3 billion from Medicare that pays for resident salaries, benefits, administrative overhead, and faculty teaching. IME dollars already provide a mandate for hospital administrators to support a robust clinical learning environment, without the need to view trainees in additional profit-making roles.

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Overall, the "Call to Action" advocates that health care executives should embrace CLER for its ability to leverage trainees to achieve hospital goals. While this may encourage health care executives to participate more fully in CLER, it represents a major shift in the program's purpose. GME can and must partner with sponsoring organizations to achieve the goal of outstanding patient care. However, it is unlikely that the CLER initiative or residents will fix major problems beleaguering the health care organizations that sponsor GME programs. Health care leaders, who aim to optimize the business of health care, and GME leaders, who aim to optimize trainee education, can find common goals and synergy of efforts, particularly those that promote high-quality, safe patient care. Achieving CLER aims is not optional if the institutional vision includes continued production of competent physicians.

The CLER program was implemented to improve the clinical learning environment for trainee education, rather than to improve an institution's bottom line. It was inspired by the recognition that the clinical learning environment of trainees may affect their future performance, independent of other aspects of their clinical education. "The feedback provided by the CLER program is designed to improve how clinical sites engage resident and fellow physicians in learning to provide safe, high-quality patient care."[3] Residents and fellows who train in a setting that promotes patient safety, physician well-being, ongoing quality improvement, the highest standards of professionalism, and successful transitions of care should be better prepared to perform well in these areas in future clinical settings after graduation. Ideally, helping the institution achieve its goals, including financial success, should dovetail with improving the training environment for physician trainees; however, this is not a given. From our point of view, educators need the leverage and tools to work collaboratively with institutional executives to achieve CLER goals—*now*.

References

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Gail M. Sullivan, MD, MPH, is Editor-in-Chief, *Journal of Graduate Medical Education* (*JGME*), and Associate Director for Education, Center on Aging and Professor of Medicine, University of Connecticut Health Center; **Jeffrey S. Berger, MD, MBA,** is Associate Editor, *JGME*, and Associate Professor, Anesthesiology, Associate Dean for GME, and Designated Institutional Official, The George Washington University School of Medicine & Health Sciences; **Lalena M. Yarris, MD, MCR,** is Deputy Editor, *JGME*, and Director, Emergency Medicine Residency and Education Fellowship Programs, Oregon Health & Science University; **Anthony R. Artino Jr, PhD,** is Deputy Editor, *JGME*, and Professor and Deputy Director, Division of Health Professions Education, Department of Medicine, Uniformed Services University of the Health Sciences; and **Deborah Simpson, PhD,** is Deputy Editor, *JGME*, Medical Education Programs Director, Aurora UW Medical Group/Academic Administration, and Professor of Family & Community Medicine, Medical College of Wisconsin (Adjunct).

Corresponding author: Gail M. Sullivan, MD, MPH, University of Connecticut Health Center, Center on Aging, 263 Farmington Avenue, Farmington, CT 06030-5215, gsullivan@uchc.edu