American Medical Association Journal of Ethics

March 2016, Volume 18, Number 3: 258-263

POLICY FORUM

Graduate Medical Education Specialty Mix and Geographic Residency Program Maldistribution: Is There a Role for the ACGME?

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Over the past 25 years, considerable discussion and debate among legislators and the general public have centered on issues raised by the specialty mix and geographic distribution of graduate medical education (GME) programs and positions in the United States. Most recently, the Institute of Medicine examined strategic oversight, funding, governance, specialty mix, and geographic distribution of GME [1] and noted the following:

> many studies have shown that the current GME program does not produce adequate numbers of physicians prepared to work in needed specialties or geographic areas. Nor does it train physicians to practice in the community-based settings where most Americans seek care [2].

Since a significant percentage of graduates of GME programs enter clinical practice in geographic proximity to their final GME program's location [3], the specialty mix and geographic distribution of GME programs are essential considerations in the geographic distribution of practicing physicians.

Frequently promulgated solutions to perceived or actual deficiencies—in numbers of generalists, residency positions, or internists (as compared to family physicians)—include participation by the Accreditation Council for Graduate Medical Education (ACGME) in shaping the specialty mix or geographic distribution of the physician workforce [1]. This might appear to be a logical approach, especially insofar as, internationally, the same government entities, such as ministries of health or education, are charged with both overseeing GME programs in their countries and implementing national workforce plans.

In the United States, however, private entities commonly perform some functions accomplished by government entities in other countries [4]. The ACGME is one such entity, recognized and relied upon [5] by resident physicians, prospective resident physicians, and patients, as well as a wide array of societal and professional entities, as the primary source of accreditation oversight of GME. Also reliant on the ACGME are the federal government, including the Department of Defense, the Department of Health and Human Services—for the purpose of disbursing billions of dollars of GME

reimbursement—and the Veterans Administration; state governments, through statutes and regulation; specialty physician certification boards; hospital credentialing entities; and other major membership organizations. Completion of years of GME training in an ACGME-accredited program is statutorily required of both domestic and international medical school graduates to obtain a state-issued license to practice medicine in the United States.

Thus, a reasonable assertion might be that the ACGME, as the entity entrusted with the establishment of GME accreditation standards and the evaluation of the effectiveness of GME programs in the United States, might also be the most qualified entity to be charged with implementing national physician workforce policy. Put another way, were there a national system of physician workforce needs determination and management, would not the ACGME be the entity most likely capable of (a) identifying GME quality parameters and (b) reconciling individual program and institutional aspirations with future regional and national physician workforce requirements?

Why, then, has the ACGME not assumed this responsibility? We suggest that there are three major factors that preclude the ACGME from assuming a role in implementing national physician workforce policy. The first two are unrelated to the ACGME, and the third is related to the ACGME.

First, while organizational and national reports—such as the Institute of Medicine (IOM) Report of 2014 [1] and the congressionally commissioned Government Accountability Office (GAO) report of 2015 [6], among others—address the need for both a national strategic vision for health care delivery and an organized plan for development and maintenance of the health professional workforce to support that delivery, there is currently no agreed-upon comprehensive national long-term plan for health care delivery [6]. Second, as there is currently no agreement on the structure of health care delivery, there is no basis for agreement on a national blueprint for health care workforce goals, including the number and specialty mix of physicians, and no linkage currently exists to tie the goals of such a plan to a financing plan for GME and other professional training [1, 6].

Third, if or when a national strategic vision for these elements emerges, the ACGME is not a governmental body with the authority of its functional counterparts in other countries; it is a private, not-for-profit body. Issues regarding the antitrust implications of a private, not-for-profit accreditation entity implementing national workforce policy remain, and this is this third element that we discuss here.

The ACGME was founded in 1981 to address many of the challenges faced by its predecessor organization, the Liaison Committee on Graduate Medical Education (LCGME), by consolidating accreditation of GME in the United States [7] and motivating

administrative efficiency and greater uniformity of accreditation processes among specialties. Structural aspects of the consolidation of the previously independent and occasionally duplicative residency review committees necessitated significant compromise. At its meeting on November 17-18, 1980, the LCGME voted to adopt a statement of policy, which the ACGME reaffirmed at its meeting of February 13-14, 1984, that in the accrediting process,

> the ACGME is not intent upon establishing numbers of practicing physicians in the various specialties in the country, but rather…the purpose of accrediting by the ACGME is to accredit those programs which meet the minimum standards as outlined in the institutional and program requirements. The purpose of accreditation is to provide for training programs of good educational quality in each medical specialty [8].

This policy evinces an explicit intention to comply with US antitrust law. It remains the policy of the ACGME today.

The proposition that the ACGME would or should participate in implementing a national physician workforce policy would clearly require an expansion of its purpose. ACGME has asserted, in its written response to an inquiry from the IOM committee that issued a 2014 report on the financing and governance of GME [1], that it would be willing to participate and partner with others in deliberating upon and implementing a national physician workforce system (T.J. Nasca, written communication, 2012). However, two issues must be addressed before the ACGME could assume such a role, both of which were raised in its response to the IOM inquiry.

The first relates to the need for professional support for this new role for the ACGME. The ACGME is an independent, not-for-profit entity incorporated in Illinois that is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code [9]. It has seven national member organizations [10], which have the right to nominate individuals for membership on the 34-person board of directors. (Members of the public, at-large members from the profession, and residents constitute the remaining members of the board; two federal government representatives participate in meetings of the board without vote.) Although the member organizations have only limited powers over amendment of certain of the ACGME bylaws, their support would be required for the ACGME to amend its purpose and assume a workforce responsibility on behalf of the public. As the member organizations just mentioned are either national individual membership organizations or national organizations, their approval would indicate general acceptance by the profession, as well as by the sponsors of GME programs, of the ACGME's authority to assume a prominent role in physician workforce goal-setting

and management for the benefit of the public. While it is possible that such approval could be obtained, it might not be without disagreement.

The second, and perhaps more significant, issue relating to an ACGME role in national future physician workforce policy is that this type of activity would risk exposure of the ACGME to allegations of anticompetitive behavior, i.e., antitrust. The IOM reminded us of this risk as recently as 2014:

> GME accreditation is essential to ensuring that GME programs meet professional standards and produce physicians that are ready to enter practice with required knowledge, experience, and skills. However, antitrust and fair trade prohibitions preclude accreditors from addressing broader national objectives such as the makeup of the physician workforce, the geographic distribution of GME resources, or other priority concerns [11].

For the ACGME to play a role in the implementation of national physician workforce policy, it would have to secure protection from enforcement of state and federal antitrust laws. One way to do this would be to obtain federal statutory exemption from the relevant antitrust laws, similar to prior legislation declaring resident medical matching programs (and their participants and sponsors) lawful [12-14] under antitrust law, or an express exemption for entities designated by the Centers for Medicare and Medicaid Services (CMS) to participate in workforce policy development. Alternatively, the ACGME could contract with CMS or another government agency to provide physician workforce policy development and implementation. Even then, the ACGME would still have to secure protection from enforcement of state and federal antitrust laws.

Summary

As we've stated, GME is the final common pathway toward clinical medical practice in the US. It makes sense, then, that national physician workforce policy aimed at meeting future public health demands should be directed at this phase of medical education. It would also make sense that ACGME, as the single accreditor of all residency programs in the US [15], should be engaged in physician workforce policymaking on behalf of the public. We identified three issues that must be addressed in order for the ACGME to assume this role: First, there must be a national agreed-upon and long-term plan for the design and implementation of the health care delivery system. Second, there must be a nationally coordinated strategy for identifying long-term physician workforce needs and funding mechanisms to physician and other health care professional developments. Third, in order to execute these roles, the ACGME must receive support from the profession and national and state-level statutory protection from enforcement of state and federal antitrust law.

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ISSN 2376-6980