

Virtual Mentor

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MEDICAL EDUCATION

Graduate Medical Education Financing and the Role of the Volunteer Educator

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Imagine it is 2013. You find yourself in one of the three following scenarios.

Researcher-Educator

You are a salaried faculty member at a medical center associated with a medical school. Twenty percent of your salary comes from an NIH clinical research grant and 80 percent from clinical revenue that you generate through direct patient care in your specialty. You support the deficits in your research program through surplus on your clinical revenue. You are a senior member of the department and receive no direct support from institutional sources. You teach in the integrated physiology course and the Introduction to Clinical Medicine course; you have residents and fellows on your clinical service year-round and a fellow in your research laboratory.

Clinician-Educator

You are a volunteer faculty member in a community teaching hospital that is affiliated with the local medical school. You are in private practice and generate 100 percent of your salary from direct patient care in your specialty. You support the overhead of your clinical practice, including the salary of its employees, through revenue generated by your clinical care. You are a member of the faculty of the community teaching hospital's independently sponsored residency program, serve on its clinical competency committee, and have residents and medical students from the affiliated medical school.

Program Director

You are the residency program director in an academic medical center. Seventy percent of your compensation is from your clinical work and 30 percent from institutional sources. You provide direction to the administrative infrastructure of the program and to its academic and motivational leadership. Among your duties are chairing the clinical competency committee; overseeing the residency office; recruiting residents; organizing and overseeing the education and evaluation of residents, faculty, and the program; and sitting on the graduate medical education committee of the sponsoring institution. Although this consumes more than 50 percent of your time, the institution supports 30 percent of your compensation.

In 2013, Medicare reimbursement for GME is dramatically reduced. What should you do?

The three scenarios describe levels of faculty engagement in graduate medical education (GME) today in the United States. We are blessed with a range of faculty expertise and interest, from full-time clinicians, who are expert practitioners of the art, to clinician-scientists who create new knowledge to move the art forward. Faculty with this range of skill sets (practical users of knowledge to creators of new knowledge) engage in the third use of knowledge, its dissemination, by educating students, residents, and fellows, as well as patients and families. It is this last use of knowledge—dissemination to residents and fellows—that I would like to explore with you.

Why would these three faculty members continue working to disseminate knowledge to residents and fellows at a time when all their efforts are not rewarded with “mission-based” compensation? What compels each of these faculty members, from differing institutional environments and roles, to remain engaged in the GME efforts at their institutions? I believe that the answer to this question lies in the fundamental principles that have framed our understanding of medicine as a profession and their implications for us in a constantly changing world.

These principles originate in three key traditions. The first is the Hippocratic tradition, which views medicine as a moral enterprise and the physician as the pivotal moral agent in his relationship with each individual patient. This tradition begins with Aristotle, Hippocrates, and the aspiration to do and achieve “the good,” which leads to a description of the key elements of physician practice. Justice, altruism, scientific knowledge, prudence or practical wisdom (phronesis or clinical judgment), honesty, integrity, charity, courage, and other virtues have their roots in the Greek tradition of the good. These concepts were further developed during the Middle Ages through exploration of the virtues by Aquinas and Maimonides, among others, and, in our era, placed in the modern context by Edmund Pellegrino and David Thomasma in their descriptions of the virtuous physician.

The second tradition starts with the evolution of medicine from a guild to a profession. The beginning of this transformation is ascribed to John Gregory in his *Lectures on the Duties and Qualifications of a Physician*. These were heavily influenced by David Hume’s writings concerning human sympathy and Francis Bacon’s work on scientific excellence. Thomas Percival is credited with synthesizing these elements into a conceptual framework for the profession of medicine in 1803. Subsequent efforts have further refined and molded these concepts in the context of medical practice, as the science and delivery of health care have evolved. Pivotal for this discussion is this tradition’s insistence that professionalism requires each physician to demonstrate commitment to competency, altruism, and medicine as a public trust. Explicit in the notion of “medicine as a public trust” is the responsibility of the profession to produce the next generation of physicians to serve the public.

Finally, the third traditional underpinning of medicine is the justice-based equitable distribution of the “good” of health care in a society. Perhaps the most influential philosopher and political scientist in the modern era in the United States is John

Rawls. Rawls constructed a theoretical framework for a just democratic society, “justice as fairness,” and described principles that should guide the creation of the institutions within it that would assure justice. Connecting his theoretical concept of justice as fairness to the practice of medicine are, among others, Madison Powers and Ruth Faden. These thinkers view the implementation of justice in the social context as society’s responsibility to secure its citizens the opportunity to achieve a state of “well-being.” They describe six elements of well-being: health, personal security, reasoning, respect, attachment, and self-determination. Physicians, in their day-to-day activities with patients, are engaged with three of these elements—health, personal security, and self-determination.

These three traditions form the fabric of professionalism as we know it in American medicine today. They both inform the content of the knowledge, skills, and art that we teach and set forth the expectations of the responsibility we voluntarily assumed when we recited the Hippocratic Oath, the Oath or Prayer of Maimonides, the Physician’s Oath in the Declaration of Geneva, or other promises made at graduation from medical school. Pivotal in this “social contract” we all enter is the responsibility to treat the profession as a public trust.

This responsibility to maintain the profession as a public trust has a number of elements. The first is that we must practice medicine and configure our abilities to meet the needs that society has identified. While we have been granted the privilege of self-regulation in the United States by the public, we are expected to regulate ourselves in a fashion that assures that we meet the needs of the public, not our own needs. This is altruism in action at a professionwide level.

Second, we are responsible as a profession for the preparation of the next generation of physicians. This responsibility to assure the public that we prepare those who will replace us to meet future medical needs has been, at times, lost in the conversation about the roles and duties of physicians. This is especially true in the era of Medicare GME reimbursement, mission-based budgeting, and the regression of the profession toward guild status. I believe that our commitment to maintain the profession as a public trust compels us to assure a high-quality education of the next generation of physicians. Therefore, each of us bears some responsibility to share medical knowledge and clinical skills with those who follow us. This responsibility accrues to us independent of society’s financial contribution to the effort.

I believe the profession has lost the sense of duty to educate over the past 15 or 20 years and assumed a posture of expecting compensation in return for sharing our knowledge with the next generation of physicians. This is the two-edged sword of Medicare reimbursement for GME and “mission-based” budgeting in our academic medical centers. That is, there are dollars provided to support not only resident salaries and fringe-benefit costs, but also for faculty supervision and teaching. It should be noted that, since the source of funding is limited to the Medicare program through its inpatient payment system, it only covers a fraction of the total costs of GME programs. Thus, even in the most educationally progressive institutions, GME

reimbursement to faculty for their educational and supervisory efforts fails to cover the costs in time and effort.

This is not a theoretical philosophical discussion in our current context. As this piece is being written, the United States, through its elected leadership, will determine whether GME funding by the federal government through the Medicare program will continue at the current level, be reduced, or perhaps eliminated completely. While one can make many compelling arguments why this is bad public policy, other exigencies may carry the day. Were significant reductions in GME reimbursement to occur, U.S. medical school faculty would need to contribute to GME by volunteering their time and expertise. Indeed, in certain circumstances, faculty clinical revenue generation may also have to provide a source of support for resident and fellow stipends.

It is reasonable to ask what the limit of altruism or voluntarism is in this circumstance. How much time and effort should, could, would we expect from members of the profession to fulfill its responsibility to the public to educate the next generation of physicians? Must every physician contribute in the same fashion, or to the same extent, in order to fulfill our commitment to medicine as a public trust?

Some of us are engaged directly in patient care, and the public trust is strengthened directly by the service we provide to our patients. In the modern context, that care should achieve the Institute of Medicine's aims of safety, quality, efficiency, and effectiveness. Those of us who have chosen careers that involve education must assure that we are effectively preparing the next generation of physicians. It is here, I believe, perhaps, that Aristotle provides us some insight. In his discussions of virtues, he points to the "golden mean" in the manifestation of virtue. Courage, for example, if manifested inadequately results in cowardice, at one extreme, and foolhardiness or recklessness at the other. Similarly, inadequate commitment to voluntarism could be viewed as selfishness, and too much voluntarism could interfere with obligations to a clinical practice and family. Whether we are clinician-scientists, volunteer clinician-educators, or residency program directors, each of us has a responsibility to uphold elements of the public trust that is medicine. We as professionals are responsible for finding a way to educate the next generation of physicians to serve the public, regardless of the nature and magnitude of Medicare GME reimbursement.

It will not be easy. But, then, medicine never has been easy. Each of the three physicians in the introductory scenarios must evaluate his or her ability and responsibility in light of individual professional commitment to the public trust. I suggest that they might consider the following elements, which I posit are required for the profession to maintain the public trust to educate the next generation of physicians.

First, each of us must identify that knowledge, those skills and abilities, and share them with those who follow in the settings in which we practice our art. We should

seek an Aristotelian golden mean, assuring that high-quality, safe care for our patients is preeminent and that the realities of personal economic survival are managed.

Second, we must have the courage to advocate for the needs of our patients and our trainees. This includes advocacy by both individuals and our professional organizations for societal support for the education of the next generation of physicians to serve the public.

Third, those of us in administrative roles must be mindful of the real costs to our faculty when asking them to share their gifts. We must structure our clinical educational programs to optimize the use of the time of the faculty and trainees. We should acknowledge, celebrate, and reward through recognition and other measures the talent and excellence of the faculty.

Fourth, those of us in leadership roles must reexamine the self-regulatory rules that we have imposed on our educational systems to assure that they are cost-effective and that they permit innovation and creativity within reasonable structure, process, and outcome requirements. This must all the while be accomplished in a fashion that assures the public that the common good, rather than our individual or collective needs, is the goal of our efforts.

Finally, we should all reflect on the promise we made voluntarily to the public to accept a life of service. By satisfying that promise to fulfill the public trust regardless of the nature and magnitude of public support for our educational efforts, we demonstrate the meaning of that promise.

Further Reading

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