The Future of Academic Health Centers

During the past decade and a half, academic health centers (AHCs) have been the subject of a great deal of attention. During the mid-1990s, leaders in the academic medicine community expressed their concerns about the continued viability of AHCs. More recently, both the Commonwealth Fund and the Institute of Medicine established blue-ribbon committees to identify and comment on the major challenges AHCs must address if they wish to maintain a prominent role in society.

From where I sit, it now appears that AHCs are, for the most part, thriving. There is no question that their programmatic activities continue to expand. It is also striking to observe all of the major construction projects that AHCs have under way or are about to begin. So I think there are good reasons to be optimistic about the future of these institutions.

But having said that, it is also important to recognize that AHCs are likely to be somewhat different in the future. At issue here is whether the traditional education mission of AHCs is going to decline in prominence. To be more specific, will the clinical faculties of the medical schools continue to be the primary teachers of clinical medicine for students and residents? And will major teaching hospitals continue to be the chief sites for their clinical education experiences? In short, will AHCs continue to bear the main responsibility for the clinical education of medical students and residents?

There are good reasons for believing that in the not-too-distant future a growing number of students and residents will be learning clinical medicine outside of AHCs. Indeed, the migration of students from the inpatient services and clinics of major teaching hospitals to a variety of community-based clinical care sites has been under way for a number of years. In many medical schools, students are now fulfilling core clerkship requirements in community hospitals, community health centers, multispecialty group practices, and the offices of individual practitioners. In a very real sense, the clinical education of medical students is increasingly being achieved by placing students in structured apprenticeships in which community-based practitioners are the students' teachers and mentors. Recognizing this, many schools are devoting considerable resources to enhance the educational experiences provided in those settings.

It now appears that the migration of residents from the inpatient services and clinics of major teaching hospitals is about to begin. For the past few years, the internal medicine community has been struggling to come to agreement on the redesign of residency training in internal medicine. All of the major organizations—the American College of Physicians, the American Board of Internal Medicine, the Society for General Internal Medicine, and those that compose the Alliance for Academic Internal Medicine—agree that changes are needed to align the training of internists with the current realities of internal medicine practice. This is a worthy goal that deserves the support of the entire academic medicine community. And while there is not full agreement on the nature of the changes that should be adopted (as I write this in early January), it appears that the following is likely to occur.

Core training in internal medicine will likely decrease from three years to two years, thus allowing residents to track into more specialized training beginning in their third postgraduate year. If this occurs, residents who aspire to be hospitalists will spend their third year on the inpatient services of hospitals, but those who wish to practice as general internists will spend much of their third year in ambulatory-care settings. And those who wish to subspecialize—the majority of internal medicine residents—will begin "fellowships" in one of the internal medicine subspecialties. It also appears that during the two years of core training, residents will spend more time learning how to care for patients in ambulatory care settings. This will likely be accomplished by eliminating the residents' continuity-clinic experiences and creating blocks of time (rotations) devoted entirely to ambulatory-care experiences.

So what effect will this have on the medical schools and hospitals that compose the country's AHCs? I think the effect will be pretty profound. Realize this: If the redesign effort turns out much as I have described it, a significant number of the internal medicine residents who now cover the inpatient services of teaching hospitals will no longer be available for those assignments. The majority of the current third-year residents will be serving as first-year fellows or as general internal medicine residents assigned to ambulatory-care settings. In addition, first- and second-year residents will be assigned full-time to ambulatory-care blocks instead of attending continuity clinics while also assigned to inpatient services. So who is going to cover the inpatient services and clinics now covered by internal medicine residents? Therein lies a major challenge that AHCs will have to confront in the near future.

But the challenge will not end there. The surgery community has indicated the need for a redesign of residency training in general surgery and other surgery specialties. A blue-ribbon committee composed largely of chairs of surgery departments worked for several years to develop a plan for accomplishing this. While there is not full agreement among the various parties about how to proceed, it seems inevitable that changes in surgery residencies will occur. And the pediatrics community has just begun a redesign initiative that will lead to changes in pediatrics residencies. It is difficult to imagine that the outcomes of these efforts will not affect residents' coverage of inpatient and clinic services of major teaching hospitals. While the effects may not be as pronounced as those resulting from the internal medicine redesign

effort, they will undoubtedly add to the challenge facing AHCs.

I think there are only three viable alternatives for meeting this challenge: (1) major teaching hospitals will find themselves having to hire physicians (hospitalists) or other health professionals (advanced practice nurses or physicians' assistants) to provide the patient care services now provided by residents, or (2) faculty practice plans will have to hire those individuals, or (3) the clinical faculty will have to provide those services themselves. The negotiations between the hospital administrative staff and the medical school or faculty practice plan administration over how this issue should be resolved will be highly charged in many AHCs. But the relevant issues will have to be settled to ensure that the hospital patients are well served.

If anyone presumes that this challenge will simply fade away over time, they should be aware that there are other activities under way focusing attention on the need to redesign residency training in this country. The Agency for Healthcare Quality and Research has supported conferences focusing national attention on the issue, the Association of American Medical Colleges has several initiatives in progress that relate to it, and several AHCs have established programs to promote residency redesign from within. Accordingly, it would behoove all AHCs to begin to plan for how they will respond once the various initiatives reach fruition.

The end result of these residency redesign efforts will be that the education mission of AHCs will be less prominent in the future than it is today and that, in one way or another, AHCs' clinical faculty will have greater responsibility for providing a range of patient care services than they do now. The impact this will have on the other missions of AHCs, particularly their clinical research mission, will become apparent only as the strategies for providing the patient care services now carried out by residents begin to unfold.

We should not underestimate the potential seriousness of this issue. Accordingly, I believe that the leadership of AHCs should anticipate the future and begin now to plan for how they will respond to the outcomes of the redesign efforts for medical students' and residents' education so that the research and patient care missions do not suffer when AHCs' role in clinical education declines.

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