Pay to Play: 
The Future of Clinical Clerkships?

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Brief History of Medical Education in the United States

• 19th Century Models of Medical Training:
  – Apprenticeship: students worked with a practicing physician
  – Proprietary schools: students attended courses given by physicians who owned the college
  – University: clinical and didactic training at a University affiliated school
In what year did African American medical students have the LEAST ACCESS TO TRAINING?

- A 1895
- B 1925
- C 2000
19th Century Models

• Problems:
  – No admission standards
  – No length of training standards
    • No equipment or laboratory standards
  – No curricular standards
  – No financing uniformity

• Benefits
  – Diverse training possibilities
  – Wide ranging content available
Meanwhile, at the University of Pennsylvania.....

• Who was the first Dean of the College of Medicine?
  – Benjamin Rush
  – Benjamin Franklin
  – John Morgan
  – Ichabod Wright
The School of Medicine created a Paradigm Shift (in the 1870s) by:

• Paying faculty to teach courses
• Integrating community service into the curriculum
• Building its own teaching hospital
• Accepting women
Medical Education at University of Pennsylvania

• Medical School created at the ‘College of Pennsylvania’ in 1765
  – Creating the ‘University of Pennsylvania’
    • John Morgan the first Dean
    • Medical faculty distinct from College Faculty
  – Clinical work at Pennsylvania Hospital (1751)

• West Philadelphia campus move 1870s
  – HUP the first teaching hospital built FOR the Medical School
Dawn of the 20th Century

• Scientific advances influence practice
  – Vaccination
  – Antisepsis
  – Public sanitation
• Call for inclusion of more science in training
• In 1904, AMA created the Council on Medical Education
  – Commissioned a survey on Med Ed
The Title of that Survey was:

- The Flexner Report
- The Harford Commentary
- The Osler Analysis
- The Roosevelt Commission
The Flexner Report
Recommendations from Flexner

• Students learn by doing
  – Critical of lecture dominated learning
  – Advocated for active and contextual learning
    • The Hospital as laboratory
    • Science laboratories used in training
  – Multiple pedagogies
    • Bedside teaching, case work, laboratories
  – Life long learning
    • Literature skills
Flexner -2

• School/hospital
  – School should own the hospital
  – Hospital size and resources adequate to size of school
  – Staff should be faculty of school
  – Dean should have control of school and hospital
  – Department Chairs should be service chiefs at Hospital
Flexner 3

• Standards
  – Admission: at least 2 years of college, knowledge of chemistry, biology, and physics
  – Curriculum
    • 2 years of basic sciences, 2 years of clinical sciences

• Financing
  – Endowments for facilities
  – Donated teaching time for faculty
Relevance to Today’s Training

• Admission standards
  – Move to added training prior to admission

• Curriculum
  – Reconsideration of 4 year duration
  – Growth of training in out-of-hospital sites
  – Growth of humanism elements of curriculum

• Financing
  – Increased importance of fed supported loan programs
  – Ever increasing tuition costs
Costs of Medical Student Clinical Training 2016

• In-Hospital
  – Number of beds available
  – Training space, equipment
    • Multi-headed stethoscopes/microscopes, SIM centers
  – Teaching time across the spectrum
  – ? Productivity

• Out of hospital
  – Space
  – Teaching time
  – Productivity
    • FM study: med Students in primary care office
      – Increases length of workday
      – Increases costs by $100-$200/day – Anthony et al
Who should bear the costs of this training?

• Students?
  – Already paying tuition for clerkship year
  – Mean approx. $55,000/year tuition and fees

• Medical Schools?
  – For owned practice sites?
  – For outside practice sites?
    - VA/non VA

• Government sources?
  – Taxes? Revenue(Medicare)

• Insurance payors?
Physician Clinical Teachers

• “Moral and professional” duty to train future generations of physicians
  – Many physicians self-employed
  – ‘Luster’ on a practice to serve as a teacher

• Free standing hospitals
  – ?Incentives to teach

• Physician employees
  – Concerns about productivity from physicians and systems
Incentives Available
AAMC 2014

• Faculty positions
  – New tracks to accommodate
• Professional development opportunities
• Library access
• Public recognition
Additional Barriers to Training Sites

AAMC Survey 2013

• Legal requirements
• Security requirements
• Training and orientation of practice faculty/staff
• Greatest limitation in pediatrics, ob/gyn, and primary care
• Respondents more concerned about competition from US schools than off-shore
Competition elements

AAMC Data

- More medical schools
  - Since 2002, 16 new MD, 7 new DO, 57 new NP programs
  - More trainees
    - 18% increase at MD, 96% increase at DO,
    - More disciplines
      - 215% increase in enrollment in NP programs
      - Nursing, Pharmacists, Rehab specialists
    - Similar challenges in Veterinary Schools
  - Increased pressure on clinical training sites
Outside U.S. Medical Schools and Training

• Proprietary Medical Education
  – DeVry Corporation owns 2 Caribbean schools
    • Ross, American U of the Caribbean
    • Operating income for health care ed in 2011: $111 million
  – Higher student indebtedness (2010)
    • U.S. $170,000 for college and medical school
    • AUC students for medical school $253,072
  – Higher student numbers – 200-300 per class, 2-3 classes per year
  – Very limited clinical training sites
Innovation: Pay U.S. Sites for Clinical Training

• Money to sites to ‘host’ trainees
  – Medical Schools MD 15% paying in 2013, DO 71%,
  – 4% NP programs
• Kern Medical Center (Ca) and Ross
  – $35 million over 10 years for 100 rotations/yr.
    • $35,000 per slot per year
• St. George and NY Health and Hospital Corp
  – $100 million over 10 years for 600 medical student rotations/yr. at the 11 public hospitals
• NY Nassau University Med Center and AUC
  – $19 million over 10 years for 64 students/yr
Consequences Reported

• Stony Brook lost peds and gyn rotations to AUC
• 80% of MD and DO granting medical schools report concern about the adequacy of training sites for students
• 67% of MD and 93% of DO programs report ‘moderate to high” pressure to provide financial compensation incentives for new clinical training sites in community-based settings
Family Med Clerkship Director survey 2012

• 23% of programs paying preceptors
  
  Range $20-$500/week/student
  – Median $170/week/student
  – 63% report that preceptors are paid for teaching other learners at those sites

• Of non-paying programs, 92% did not have funds
  – 76% stated they would pay if they did have funds
Where are FM preceptors paid?

Figure 1: Preceptor Payment by the US Census Bureau’s Nine Census Divisions and Puerto Rico

23% (19/83) Clerkship Director Respondents pay their Community Preceptors
Why do programs pay preceptors? (select top reason)

• Helps with faculty retention
• Helps with faculty recruitment
• Competition with other training institutions
• Right thing to do
Why pay?

Figure 2: Reasons for Paying Community Preceptors by Order in Which They Were Selected by Paying Respondents.*

<table>
<thead>
<tr>
<th>Reason</th>
<th>First Choice</th>
<th>Second Choice</th>
<th>Third Choice</th>
</tr>
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<tbody>
<tr>
<td>We have the funds</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Necessary for quality</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Right thing to do</td>
<td></td>
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<td></td>
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<tr>
<td>Competition</td>
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<tr>
<td>Helps with recruitment</td>
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<td></td>
<td></td>
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<tr>
<td>Helps with retention</td>
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</tbody>
</table>

*Weighted
* Ranked sums represent sum of responses in which each first choice is given a score of 3, each second choice is given a score of 2, and each third choice is given a score of 1.
In FM programs NOT paying, why? (select top reason)

• School cannot afford
• Don’t want to set a precedent for other departments at the school
• Don’t want to set a precedent for other schools in the area
• Devalues teaching as a part of professional practice
Why not?
106 Years Post Flexner

• Science is part of curriculum
• Most schools make use of adult learning techniques
• The student body is diverse
• Life long learning is a reality
• BUT
  – Widening rift between clinical training sites and schools
  – Push towards proprietary training is returning
Change?

Figure 10. Dr. Adolf Lorenz operating on a patient with clubfoot at the Good Samaritan Hospital. Photo reprinted from Rosser CM. Doctors and Doctors. Wise and Otherwise.
Summary

• Increased competition for training spots will continue

• For School Owned Sites
  – Triage may be easier
  – Range of compensations wider

• For Independent Sites
  – Financial compensation likely to win out
  – Schools may need to look harder at dispersal of tuition
  – Is payor/grantor pressure likely????
References


• Halperin ED and RB Goldberg. Offshore Med Schools are Buying Clinical Clerkships in U.S. Hospitals. Academic Medicine in press

• AAMC. Recruiting and Maintaining U.S. Clinical Training Sites 2014
References 2
