EDITORIALS

Are We Making Progress in Medical Education?

Scholarship in medical education consists of a rich compilation of studies and innovations designed to enhance our understanding of the process and content of education, contributing to and enhancing the training of physicians and their practice of high-quality patient care. Viewed through the lens of the Society of General Internal Medicine (SGIM) Residency Reform Task Force Report,[1] the 29 reports in this issue advance our understanding of the educational mission and vision for a broad range of topics.

1. *Residency training should be based on learning patient-centered, high-quality care for adults.*

Since the majority of residency training is experiential—learning while providing care, implicit in this statement is the importance of understanding the learning environment from patients' perspectives. In this issue, several authors make important contributions to our understanding of the learning climate. Further, a curricular shift is underway. A focus on explicitly learning from mistakes, understanding medical errors and the meaning of empathy, appreciating the richness of culture and its influence on patient centered care, understanding patients' spiritual needs or, at the very least, how to begin the dialogue with patients about their spiritual needs, and creating tools to practice skills on models that move us away from bedside practicing on patients all contribute a richer understanding of the meaning of patient-centeredness. Several papers help us to see our learning environments through the eyes of medical students, and the importance of context in learning.

2. *Training programs will need to become more flexible to meet the diverse career needs of its trainees and programs must ensure progression is clearly based on achieving benchmarks of clinical competence.*

Career paths for general internists continue to diversify. Several authors provoke us to consider different skill sets for different trajectories and curricula that influence career choice. Although most of the research in medical education published in this issue continues to occur in isolated, single institution studies attenuating any conclusions we might want to draw, we should be concerned that preparation for practice is inadequate in some areas. How competent should graduates of any internal medicine training program be in interpreting chest x-rays? How important is knowledge of Medicare billing guidelines? Should all graduates be competent to perform joint injections independently? Are faculty at benchmark competence? While we ponder these important questions, educators are advancing our knowledge of effective teaching methods for some of these questions and measurement tools to assess effectiveness of others.

3. *Health care work processes in teaching hospitals and clinics need substantial redesign.*

Work hours regulations have already changed the training experience and work processes for residents and faculty. Authors in this issue advance our understanding of the impact of these changes (not all positive) and residency programs' responses to them. While work hours changes have presumably improved quality of life for trainees, there appear to be negative affects on faculty. Future innovations and investigations should examine impacts on faculty who may themselves be pushed to unsafe workloads. None of the papers in this issue suggest or evaluate new radical program redesigns. The Education Innovations Project[2] about to begin in a number of residency programs around the country may be our best opportunity to foster and learn from more radical change.

4. *The primary mission of the residency program should be the integration of patient care and education.*

Programmatic responses to external regulation continue to drive program redesign. In spite of these pressures, educators continue to challenge us to focus on the integration of patient care and education. Through continual innovation, evaluation, and redesign emerge important ideas for integrating the use of evidence in making patient-centered decisions at the point of care and create life-long learners in the profession. Much work remains to further our understanding of the relationship between service and learning in shaping future physicians' work habits and professional attitudes.

5. *Redesign of internal medicine training must promote collaboration among residency programs for better education research.*

Some of the authors published in this issue designed and executed multi-institutional studies, creating power for interpretation and dissemination. By far the majority of papers submitted for this issue were unfunded studies from single institutions with unique situational factors. These studies represent "real-time" problem solving in challenging naturalistic environments. Although we hope the readers of the studies chosen for publication will appreciate the degree of innovation presented here and perhaps find a springboard for their own work, it is critical that we address barriers to collaboration and rigorous methodological study design in medical education research if we ever hope to make evidence-based programmatic decisions.

We must learn from those who are successful in their collaborative efforts. Perhaps their successes suggest that interest groups of SGIM and other academic societies represent an informal network that might foster more explicit opportunities for collaboration.

The SGIM Task Force Report, and the myriad reports from other organizations in academic and clinical medicine attest to the need to look broadly, but urgently at our clinical education

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enterprise. Pressures on our educators continue to rise with changing parameters of productivity expectations, reimbursement systems, and new models of care that can sometimes seem very peripheral to our education mission. And yet, it is with the imperative to do well for our patients and our learners that clinician-educator scholars engage in improvement efforts.

These papers represent some progress, and taken together imply that passionate, devoted clinician educators will continue to ask and answer important questions that will make a difference in the lives of patients, learners, and teachers. Key to the success of these efforts will be our ability to develop models for collaboration in medical education research, mechanisms to fund this work, and efforts to measure clinical outcomes as proof of success in medical education.—**Carol K. Bates, MD,[1] Stewart Babbott, MD,[2] Brent C. Williams, MD,[3] David T. Stern, MD, PhD,[3] Judith L. Bowen, MD.[4]** *[1]Beth Israel Deaconess Medical Center, and Harvard Medical School, Boston, MA, USA; [2]University of Kansas School of Medicine, Kansas City, KS, USA; [3]University of Michigan Medical School, Ann Arbor, MI, USA; [4]Oregon Health and Science University, Portland, OR, USA.*

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