Ochsner Journal 16:10, 2016

Medical Education – Evolving

William W. Pinsky, MD

Executive Vice President Chief Academic Officer, Ochsner Clinic Foundation, New Orleans, LA
Head and Professor, The University of Queensland School of Medicine, Ochsner Clinical School, New Orleans, LA

When considering how we organize and deliver medical education, I truly believe that on the whole, our US health system, while flawed, can provide quality and safe care. I am an optimist and believe that the physicians we train are competent to do this. In fact, one of the reasons so many international graduates apply for graduate medical education (GME) in the United States is because of the opinion in many countries that the United States is the gold standard for medical education. So instead of focusing solely on competencies, maybe the questions medical educators should be asking today include "Are we doing all we can to ensure that our graduates are armed with the tools and capabilities to meet our social obligations to our communities?" "Can we do a better job of identifying the candidates to become physicians and are they properly prepared?"

Having thought about these questions, I find it amazing that for all US physicians, whether we trained decades ago or graduated in 2015, our education has been based on the 1910 Flexner report.[1] It is incredible to think that for more than 100 years, the structure of medical school has been essentially the same: 4 years that includes 2 preclinical years and 2 clinical years. Clearly, over the decades, the curriculum has had some ebbing and flowing of changes—from the introduction of community medicine in the 1960s to problem- and team-based learning more recently.

One thing we know for sure is that we do a good job of admitting students to medical school who are good test takers. However, are we confident that we are admitting students who will be good empathetic caregivers? While we have some wonderful physicians, what concerns me is that our admission test score metrics may be driving away and ultimately rejecting good applicants solely based on scores. The interview process, even the newly devised intricate interview processes, may weed out a number of applicants who are not academically qualified and readily demonstrate something that disqualifies them for admission, but interviews still do not offer any real assurances that the interviewee/applicant is an empathic/spiritual individual.

The authors of the new Medical College Admission Test (MCAT) have invested a lot of time and expertise to produce a test that can generate more than a score that just measures one's (science) knowledge. The intent is to capture a broader picture with images of the applicant's capabilities to use knowledge of the natural, social, and behavioral sciences and to solve problems; the new MCAT purports to measure whether candidates will be able to focus on the foundational competencies required of physicians, such as learning and thinking like scientists. Can they employ scientific and critical reasoning skills? In a sense, the new MCAT attempts to test broader skills and knowledge across the sciences. Jordan Cohen's op-ed piece in *JAMA* asks the correct question of the new MCAT, "Will changes in the MCAT. . .ensure that future physicians have what it takes?"[2]

Metrics are certainly important; however, there are individuals who believe—for all activities—that if it can't be measured, it is not worth doing. I believe that approach is a bit over the top. The United States Medical Licensing Examination was devised to provide a common way to measure medical students' performance across medical schools; ie, it was intended to indicate whether a student had learned the proper scientific and clinical principles to allow him or her to progress to the next level. If an individual achieves the passing grade, the reasonable assumption is that s/he is eligible to continue.

However, the results of this test, in my opinion, have been misused by medical school deans to compare their schools' education and outcomes to those of other schools. More importantly, residency and fellowship program directors use the scores to establish cutoff levels for determining whom to interview for GME positions. These uses were not the intention behind the development of the test, and I am not convinced the score itself gives specific enough information to program directors. The result is that candidates who may be the best prospects to be successful in a particular field may not be the ones chosen. Another result is a tremendous amount of unneeded stress for the student applicants.

In summary, the practice of medicine continues to evolve. We are experiencing unprecedented changes due to technological and scientific advances and at the same time there are intense economic pressures on our profession. To paraphrase and to add to Dr. Cohen's thoughts, "Are we creating physicians who will have the tools (emotionally, scientifically, spiritually) to be able to lead, manage, and create transformative changes?"

REFERENCES

1. Flexner A. *Medical Education in the United States and Canada*. Washington, DC: Science and Health Publications, Inc.; 1910.
2. Cohen JJ. Will changes in the MCAT and USMLE ensure that future physicians have what it takes? *JAMA*. 2013 Dec 4;310(21): 2253-2254. doi: 10.1001/jama.2013.283389.