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The Value Added to Clinical Care by Medical Education

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The Value Added to Clinical Care by Medical Education

Policy-makers are concerned about the cost of medical education. It is easy to understand why. The average annual cost of educating a medical student is estimated to be somewhere between $40,000 and $93,000 according to one of the most recent of over 120 articles published on this topic over the past three decades.[1] However, the cost alone is misleading. A complete understanding of the cost of medical education* must also consider the benefit, or value-added component of these activities. By focusing on cost and ignoring this concept of value, policy-makers place undue emphasis on the negative aspects of training to the detriment of medical education, as well as other health professions education.

Jefferson's Center for Medical Education Research and Policy, supported by the federal Health Resources and Services Administration, is currently participating in a national study of the value of medical education to integrated delivery systems. The study is being directed by James Boex, MBA, of Northeastern Ohio Universities College of Medicine and Linda Headrick, MD, of Case Western Reserve University College of Medicine. Boex recently completed a major study of the cost of clinical training[2] and Headrick has published widely on continuous quality improvement, including education.[3]

Boex and Headrick, together with other leaders in medical education, are reminding policy-makers about the very real value of medical education in the clinical setting. The literature on the value of education to an entity such as a health system is limited. The publications available provide limited guidance. There do appear to be significant benefits in four areas. The first is higher quality. Health systems and their customers (i.e., patients and their employers) usually perceive that settings with trainees offer the highest quality health care. The second is physician satisfaction and retention. Health systems and other types of organizations involved in education find that many of the best physicians prefer to work in settings that include medical students and residents. Therefore, these physicians are more satisfied with their professional practice and are more likely to remain within the system. The third benefit is physician recruitment. Health systems, their medical directors and their staff physicians usually attach value to trainees because they have the opportunity to evaluate the trainees' performance before bringing them into the system permanently. Closely tied to this are reports that these new physicians are more readily acclimated to the new practice environment. Finally, the fourth benefit is service and productivity. A well-managed health system can create value from the efforts of residents in particular, as well as students. This is especially true of advanced (third and fourth year) students.

Representatives of the leading stakeholders in managed care organizations and academic medicine are now being interviewed to amplify our understanding of these benefits, and to expand the list. Although beyond the scope of the present study, to be completed later this year, the challenge of future studies will be to assign more concrete values to these types of benefits, toward better informing all stakeholders, including educators, managers, and policymakers, among others.

A complete bibliography of over 120 articles with abstracts on the cost and value of medical education is available at http://jeffline.tju.edu/CWIS/DEPT/CMERP/.

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