The Importance of an Environment Conducive to Education

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The first national report of findings from the Clinical Learning Environment Review (CLER) Program, published as a supplement to this issue of the *Journal of Graduate Medical Education*, is a very important initiative recently undertaken by the Accreditation Council for Graduate Medical Education (ACGME).[1] Prior discussions about interventions to improve the quality of graduate medical education (GME) have included important issues, such as standard setting, the balance of service and education, assessment, sites of training, and the content of training. The focus has been primarily on individual program review. More recently, the general quality of the learning environment in which GME takes place has been raised as one of the most important elements in determining the quality of the educational experience. This, of course, is not an entirely new idea, but it has risen in significance in an era of more rapid clinical throughput, increasing intensity of care in all clinical settings and increasing economic pressures on faculty and sponsoring institutions. One of the conclusions of a Macy Report on GME in 2011 was that "GME must be organized and supported at the institutional and national levels to ensure that residency and fellowship programs are designed and conducted according to sound, broadly endorsed educational practices, *within an environment conducive to education*."[2]

The CLER initiative is the first significant attempt to formally assess that learning environment so it can be improved. The review chose 6 areas of focus to evaluate the environment: patient safety, health care quality (including health care disparities), care transitions, supervision, duty hours/fatigue, and professionalism. The findings should serve as a wake-up call; there is much we can do to improve the learning environment. This is not because we do not have conscientious faculty overseeing training programs; rather, it reflects the intensity and complexity of the environment in which training is occurring. There has generally not been enough effort to make the education mission synchronous with the care mission and with the overall success of the institutions. As a consequence there is the risk (and the reality) that education becomes marginalized and is seen as less relevant to the institution's mission.

The specific findings of the report include both encouraging news and guidance for areas of improvement. In the area of safety, it is encouraging that almost all residents are being exposed to the principles of patient safety. Much more needs to be done, however, to involve them in a meaningful way in the real work of reporting, analyzing, and improving patient safety in their institutions. This is a missed opportunity for learning and a missed opportunity for using the experiences of talented front line health professionals.

In the area of health care quality, residents are aware of the quality priorities in their institutions, and most are participating in some projects. They are not, however, as knowledgeable as one would want them to be in the concepts and methodology of quality improvement work. This is another lost opportunity for learning and for institutional improvement. In the related area of improving health care disparities, resident knowledge and involvement is highly variable. Unlike patient safety and quality of care where there are mandated structures, activities, and reporting in all institutions, there are not comparable standards or structures in health disparities. This creates an opportunity for residency programs to take a leadership role in this important area.

Care transitions are central to the activities of all residency programs, including both "internal" transitions (handoffs) and transitions from one site of care to another. This is another area where residency programs could (and in some cases they have) provide institutional leadership. This also is an important area for residents to be engaged in interprofessional collaboration and interprofessional learning.

Supervision is an area that has improved markedly in recent years, and the residents do report that they feel they are closely supervised. There is still much we have to learn about how to titrate supervision appropriately to allow for the full development of clinical judgment and the ultimate readiness for independent practice. We need to achieve greater understanding of how appropriate supervision can positively contribute to professional development. We

DOI: http://dx.doi.org/10.4300/JGME-D-16-00129.1

also have not taken full advantage of the insights to be gained from experienced interprofessional supervision.

The ACGME has taken a leadership position through courageous decisions in the areas of duty hours and fatigue management. There is no doubt that this has dramatically changed the environment in this area. But it is not surprising that this has not solved all the problems. Programs, faculty, and residents are still struggling with the application of the duty hour rules, and it is likely that modifications will be forthcoming based on research that is now being sponsored by the ACGME. It is also important to realize that there is more to resident fatigue and burnout than just duty hours. Adequate attention needs to be given to work load, work conditions, and personal factors. The ready availability of counseling and emotional support for residents is an important part of the optimal clinical learning environment.

Programs, in general, seem to be more aware of the importance of including discussions about professionalism in the curriculum. It is less clear that they are dealing constructively or consistently with breaches of professionalism. Professionalism for residents does not occur in isolation from professionalism for all of the staff. In evaluating the learning environment, one would want to know whether the institution supports professionalism for all the staff through its policies and incentives. Is bad professional behavior of the staff called out, corrected, or disciplined?

The CLER initiative will lead to some important questions about values and culture at the sponsoring institutions. How important is education in the organization? Are learners valued or seen as a burden? Are investments made in faculty development for teaching? Does the institution foster a collaborative team approach to care that is a model for learners? Is there mutual respect among all the health professions? How does the institution relate to and help the community it serves? Are patients included on advisory groups and is shared decision making encouraged and supported? How these value questions are answered can have a profound effect on the overall quality of the educational experience and on the kind of physicians we produce.

At a time of dramatic change in health care delivery and important necessary changes in how we prepare physicians for 21st century practice, it is imperative that we develop closer links between education and health care delivery.[3] We need to stop thinking of education and health care delivery as 2 separate systems, but rather think of them as united in the common goal of improving the health of the public they serve. I believe we have undervalued our residents (and other learners) as important members of the health care team and as contributors to improvements in our health care delivery system. We need to change this value equation. The CLER initiative is an important step in that direction.

References

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