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AGA INSTITUTE

AGA Institute Future Trends Committee Report: The Future of Gastroenterology Training Programs in the United States

The American Gastroenterological Association (AGA) Institute Future Trends Committee (FTC) developed this report based on a consensus conference it convened on March 8–9, 2008, in Washington, DC. The report was prepared for the FTC by Carol Regueiro, MD, MSc, a medical writer under contract to the AGA Institute, and Michael Stolar, PhD, staff liaison to the FTC. This report was approved by the FTC on July 1, 2008, and accepted by the AGA Institute Governing Board on July 26, 2008.

On March 7–8, 2008, the Future Trends Committee (FTC) of the American Gastroenterological Association (AGA) Institute convened a consensus conference to (1) assess scientific, technological, social, and economic changes affecting the practice of gastroenterology and (2) consider changes to fellowship training that might better prepare future gastroenterologists individually and the field as a whole to meet the demands of coming years. At the conference, the FTC heard presentations from invited experts who summarized how recent changes to the economic, social, educational, and research environment have challenged traditional training and practice paradigms. These experts also presented potential strategies for coping with these challenges. This report contains the FTC's interpretation of key points from these presentations and the conclusions that it derived from them. It presents a series of recommendations from the panel directed to the profession at large and to the AGA/AGA Institute. The recommendations include changes to the structure, content, and delivery of fellowship training with an emphasis on increased flexibility within fellowship to tailor education to trainees' specific career goals. In addressing the identity and training of hepatologists, the panel believes that although hepatology must remain part of the broader field of gastroenterology, significant changes in gastroenterology training should be made to accommodate those fellows who wish to specialize in this area. The panel also suggests that the AGA Institute explore combined training options in advanced endoscopy and surgery, and gastroenterology and oncology, as well as support efforts to bolster and stabilize fellowship funding in general. Future gastroenterologists face many challenges posed by changing economic, political, and social forces affecting medicine. Changes to fellowship training can help ensure these physicians are well equipped to successfully navigate these forces and capitalize on the many opportunities that scientific, technological, and clinical advances provide for these physicians to pursue rewarding careers.

Executive Summary

The gastroenterologist of the future will face great changes in the scope and delivery of health care, driven by significant economic and demographic pressures, social trends, and technological innovations and scientific advances. Successful physicians will need to understand and accommodate these changes to continue to thrive professionally.

The changing economics of health care is a major driver of change. Because health care costs have been rising at unsustainable rates for businesses and families, payers and consumers are increasingly demanding demonstrable transparency, quality, and value. In addition, rising consumerism and competition within the health care system will demand that gastroenterologists add demonstrable value to health care through differentiation of skills, innovation, and demonstrable quality, defined as both traditional measures of morbidity and mortality and through measures of patient access and satisfaction as well as cost efficiency.

Future gastroenterologists will have substantial opportunities to add health care value because advances in genetics, proteomics, and related fields hold the promise of improved disease prevention and targeted pharmacologic interventions. Advances in information technology, imaging, and endoscopy will make data increasingly available and will facilitate improved disease diagnosis and management. Gastroenterologists will play important roles in both clinical arenas, providing advanced endoscopic procedures and managing broad-based health care teams caring for individuals with complex gastrointestinal (GI) problems, and in management ar-

Abbreviations used in this paper: AASLD, American Association for the Study of Liver Diseases; ABIM, American Board of Internal Medicine; ACGME, Accreditation Council for Graduate Medical Education; AGA, American Gastroenterological Association; CTC, computed tomographic colonography; DGME, direct graduate medical education; DRG, diagnosis-related group; EGD, esophagogastroduodenoscopy; ERCP, endoscopic retrograde cholangiopancreatography; EUS, endoscopic ultrasonography; FTC, Future Trends Committee; GI, gastrointestinal; GME, graduate medical education; IME, indirect medical education; NIDDK, National Institute of Diabetes and Digestive and Kidney Diseases; NIH, National Institutes of Health; NOTES, natural orifice transluminal surgery; NRSA, National Research Service Awards; PRA, per-resident amount.

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eas, such as creating and administering wellness programs that address costly chronic diseases such as alcohol abuse, obesity, and other common problems. Still other opportunities will be found for those with expertise in the rapidly evolving technology of education and electronic health records.

To successfully navigate the changing health care milieu, gastroenterology trainees will need to leave fellowship with extensive knowledge of new scientific fields and with business and management skills. Changes in fellowship and postgraduate training will be necessary to equip gastroenterologists to capitalize on new health care opportunities. Gastroenterology-specific information that trainees will be expected to master will continue to increase in depth and breadth. Advanced training in areas such as clinical genetics, obesity and nutrition, women's health, geriatrics, GI malignancies, hepatology, and global health issues such as liver diseases and diarrhea will grow in importance.

To allow time for increased gastroenterology training demands, novel approaches such as potentially reducing the length of internal medicine residency and increasing fellowship training time may be necessary. Specifically, the panel recommends that all fellows receive more training about clinical genetics, GI oncology, GI imaging, and the business of gastroenterology practice whether in a community or academic setting. Furthermore, the panel suggests that the structure of fellowship be modified to allow trainees with identified interests to tailor their education to specific clinical areas such as hepatology or to basic, clinical, or translational research areas after the completion of a common general gastroenterology year. In other areas, it may eventually be most logical to support creation of combined fellowships; the panel recommends that the AGA Institute explore combined training options in advanced endoscopy and surgery, and gastroenterology and oncology, to meet growing demands. In addition, the panel suggests that the AGA Institute support efforts to bolster and stabilize fellowship funding in general.

Future fellowship programs will need to creatively address the concerns of new physicians who are likely to enter medical residencies and fellowships with substantial debt loads and competing family priorities. Successful programs will exploit technological advances to offer more efficient and effective medical training and will meet the education and lifestyle needs of individual trainees through improved flexibility in fellowship scheduling and part-time options.

Gastroenterology trainees face a range of challenges and opportunities that will profoundly change gastroenterology practice. Fellowship training cannot anticipate or completely buffer trainees from political, economic, and social forces that affect medicine. Revisions to the delivery and content of fellowship training, however, can help ensure that individual trainees and practicing gastroenterologists have the knowledge and skills to anticipate and successfully navigate these changes and that the field as a whole continues to attract and retain high-quality physicians.

Summary of Formal Recommendations to the AGA Institute

The FTC recommends that the AGA Institute should do the following:

1. Conduct a survey of how gastroenterology fellowship programs are financed throughout the United States to better understand the current structure and to inform future policy discussion.
2. Advocate for increased attention in the Gastroenterology Core Curriculum to clinical genetics and genetic counseling. In addition, it suggests that the AGA Institute develop continuing medical education programs for those already in practice to develop these competencies.
3. Work to alter the existing structure of the 3-year fellowship curriculum to accommodate trainees who wish to specialize in a specific disease area, procedure, or type of research.
4. Convene a work group to explore the potential advantages and disadvantages of reducing the internal medicine component of training to allow 4 years of gastroenterology subspecialty education within the current 6-year "3 plus 3" training model.
5. Advocate that the diagnosis and treatment of liver disease remain an integral part of gastroenterology training and practice.
6. Endorse the concept that, for trainees who wish to become hepatologists, fellowship should be structured as follows:
   - Fellowship year 1: devoted to a "survey" of common GI diseases and procedures such as colonoscopy. This would be the standard gastroenterology training year for all gastroenterology fellows.
   - Fellowship years 2–3: devoted to in-depth training in hepatobiliary disease. This most likely would include a few additional months of gastroenterology rotations.
7. Develop a well-defined advanced oncology curriculum that extends beyond that contained in the 2007 Gastroenterology Core Curriculum. In doing so, it should investigate development of GI oncology fellowship options that could include the following:
   - Fellowship years 1–2: devoted to common nonmalignant GI diseases and procedures such as colonoscopy.
   - Fellowship year 3: devoted to in-depth oncology training including chemotherapy, cancer staging, and treatment as well as procedural training about the appropriate use and performance of techniques such as endoscopic ultrasonography (EUS) and endoscopic mucosal resection.
   - Alternatively, an entirely new training curriculum could be introduced, perhaps in cooperation with