Accreditation Council for Graduate Medical Education: Strategic Plan

Solicitation of Public Comments
Summer 2014

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Information for Commenters

You are welcome to provide comments on any portion of this document, but in particular on the strategies beginning on Page 9. Your comments should be sent by e-mail to ACGMEstratplan@ACGME.org.

As an index for your comments, please reference specific document line numbers when providing commentary. There are no set limits to the length of your comments, but concise comments will be appreciated.
Introduction to Strategy Document

The year 2013 marked the transition of the ACGME into the final phase of successful achievement of the core goal of its strategic plan: to move to a new accreditation system that has both meaningful measurement of outcomes of residents, and continuous improvement of educational programs in support of those outcomes. The Milestone Project and the Next Accreditation System (NAS) with its unique dimension, and the Clinical Learning Environment Review (CLER) program, fulfill the strategic priorities approved by the ACGME Board of Directors in 2005.

With the implementation of CLER, the NAS, and Milestone measurement in 2013-2014, the ACGME decided to embark on a rigorous scenario-based planning process. This was in part due to the recognition that, in order to advance our role in ensuring the Public Trust, the ACGME must view our achievements as a foundation, rather than a completed project. Our aim was to take a long-term look at the uncertain health care system environment facing the American Public, physicians, teaching institutions, and other medical accountability organizations charged with upholding the Public Trust that is the foundation of the Social Contract. This was accomplished through the engagement of approximately 200 individuals from all dimensions of the communities of health care delivery, education, and public policy. Armed with these insights, the Board and Administration then crafted the core strategies required for the ACGME to continue to effectively serve the Public and help lead the profession in an uncertain future.

The one thing we absolutely know about the future of health care and graduate medical education is that it is completely uncertain. Therefore, we chose an approach to planning that manages uncertainty, rather than attempting to predict it. The ACGME chose an approach called “alternative futures scenario planning” as the principal analytical framework for its strategic planning.

There are several important things to note about this type of scenario planning and this project. (1) The scenarios are not forecasts of the future. They are strategic risk management tools designed to address the full range of uncertainties and ambiguities facing health care and graduate medical education in the future. After extensive research, including nearly 100 interviews across the health professions, the ACGME Core Team developed a set of four widely varied scenarios describing the future context in which health care would be delivered 20 years from now. The goal was to use the scenarios to identify insights and strategic solutions that are robust – that is, they are viable and resilient strategies that work well across the range of futures. (2) The scenarios, as originally developed, contain no specific statements about health care or health care education. The scenarios begin as the external environments within which health care must operate. The first project workshop, made up of 50 of our stakeholders in the health care community [the Strategic Advisory Group (SAG) workshop], “lived” in the four scenarios for three days and developed detailed “U.S. health care systems” for each scenario. (3) The
robust insights and strategies below are the result of the deliberations of the SAG workshop and, more particularly, the ACGME Board of Directors scenario workshop. In the Board workshop the scenarios (with health systems added) were used to develop logical medical education systems for each scenario, and then ACGME strategies that were consistent with the scenarios and those education systems. Very brief summaries of the scenarios can be found at the back of this document. The scenarios are: “Free Markets Unchained”; “Boomdoggle”; “There’s an App for That, Too?”; and “Cloudburst”.

**Insights from 2035:**
**The Context for Health Care and Medical Education**

**Overall Context for Health Care**

Across the four ACGME scenarios, the social setting within which health care will be delivered (and a healthy population promoted) will be increasingly complex and will incorporate greater uncertainties, not fewer. Even in scenarios with the poorest economic conditions, the pace of technological and societal change will slow only at the margins. Of particular note was how the wide availability of data and analysis across all sectors of the economy will impact consumer and patient knowledge and decision-making, and accelerate the blurring between health care and other sectors of society. That tendency will be further accelerated by the proliferation of home-based sensors and human-accessory or embeddable biotechnology tools allowing for automated diagnosis and automation-supported care. Adding yet more complexity for patients and consumers across all the scenarios were questions of veracity – with massive amounts of data to be analyzed and a vast number of actors claiming to provide the truth about that data, identifying what is true and reliable will be a significant challenge.

The demographics of aging were essentially the same in each scenario, but the burden created for society differed depending on issues such as economic health, technology advancement, and the breadth of the U.S. Social Contract. However, large inequities in wealth, the shrinking of the middle class, and the social disenfranchisement of those in poverty turned out to be unresolved issues in three of the four scenarios. In one of those three scenarios a potential solution seemed on the horizon. In the fourth scenario (in which inequities were resolved), the solution was in response to near societal collapse following a catastrophe. Adding complexity to this phenomenon was the assessment in all four worlds that institutions and insurance companies would be offloading more risk onto individuals, whether they were prepared for it or not. This in turn raised questions concerning the efficacy of informed patient engagement and the shifting roles physicians may have to assume to help patients navigate their way through care regimens in which they shoulder more responsibilities. Variable ranges of economic, social, and educational
attainments had a significant impact on patient ability to engage meaningfully in health management.

Internationally, none of the scenario world teams found that the global medical setting (while frequently very important) was going to be a defining characteristic of the U.S. medical system over the next 20 years. Yet, in several scenarios, the interests of global corporations often dominated the marketplace in medicine (including in the U.S.), blurring the distinction between U.S. and foreign medical systems. In some cases the insights from the international and U.S. analyses were congruent. One example is the drive for common global standards in medical education and individual professional recognition.

**Delivery and Practice of Health Care**

The models for health care delivery and clinical practice differed widely across the four ACGME scenarios and from the model used today. Nevertheless, there were some common insights and conclusions. For example, all of the scenario workshop participants saw a paradox concerning the advance of technology. On the one hand, computer-/sensor-assisted algorithm-based care might overly mechanize patient access to care at the entry level and divorce physicians from important early diagnostic activities. On the other hand, the data generated could benefit personalized patient care, and facilitate research and significantly improve outcomes. Additionally, while technology advances would improve distance care, there was an acknowledgment across the worlds that technology alone would not radically improve rural health care, and that the delivery of effective health care in rural areas would continue to be a challenge. The one group that stood out (in three of the four scenarios) as having significant influence on health care delivery was corporations; often these were global entities with little or no allegiance to the U.S.

The (first) SAG workshop in particular focused considerable attention on the meaning and centrality of “value” as the participants developed health care systems for each scenario. Two common insights emerged across the scenarios. First, the concept of value would grow in importance, impacted particularly by improvements in transparency and information systems and by the shifting of risk onto consumers and patients. The second of the insights was that the meaning of value might change dramatically and not necessarily resemble the conventional definition of quality/price (which, by the way, it would in “Free Markets Unchained”). For example, in “There’s an App for That, Too?,” value would be “community health/cost” and the evaluating entity would be massive economic-educational institutions. Whereas, in “Cloudburst” it would be quality/access and the evaluating entities would be the patient and the federal government.

A variety of conditions across all of the scenarios (including technology development, financial pressures, and patient demands for immediate solutions) led workshop participants to conclude that uncertainties in the health care setting...
would escalate, and the traditional delivery silos in health care would either blur or in some cases disappear entirely. This led to the observation that greater physician career flexibility would be needed to address shifting care needs and that interprofessional team-based care would be a central fixture across the worlds. However, the models of team-based care differed widely across the four scenarios, as did the permanence or fluidity of team leadership.

Many of the same societal pressures supported the emergence of low-price “immediate access” health care competitors with little or no close supervision by physicians. While this phenomenon was typically focused on entry-level “routine” acute care, in three of the scenarios it resulted in the commoditization of entry-level care, which led to a growing image that “all health care professionals are the same”—their expertise and advice are equally good and accurate—thus, price is the only important differentiator. This commoditization of entry-level care in turn led to an increasing tendency for providers to “push” patient care to lower-priced health care staff, automated systems, or self-care approaches. This put pressure on the meaning of professionalism across all the health care professions. An examination of all of these conditions led the scenario workshop teams to conclude that the very nature of what it means to be a "physician" will change, and physicians will be identified less by the knowledge they possess and more by their experience and judgment.

How many physicians must we have? There was no definitive answer to that critical question from the scenario analyses. In one scenario, a significant professional blurring emerged between physicians and other health care providers, and in another scenario, vastly improved sensors and computational power led to much automated care. One thing was clear: there was no compelling argument for more physicians per patient than exists in 2014. However many physicians there are in the future, all the scenario analyses indicated that the trends that fragment physicians’ societal voice in 2014 will continue or become more profound. Physicians, as a professional group, will find it challenging to speak with one voice. Finally (and related), across the scenarios, it was acknowledged that medical professionalism would be in tension with a number of societal, technological, and financial pressures. The societal “forces for change” (external to the profession) that dilute professionalism will be greater than those that promote or sustain it, unless the balance is actively managed.

Medical Education

As the scenarios provided no single-point forecast of what the future health care delivery system will look like, there is no easily defined "target" for designing the medical education system to produce the health care professionals of the future. However, the scenarios do provide a number of common insights. For example, the pace of change in educational topics and approaches will accelerate dramatically, and the impact of technology (asynchronous education, advanced simulators, personally-integrated data access, etc.) will be dramatic. Those factors alone will
have enormous implications for faculty training, and where, how, and in what sequence students are educated. Across all four ACGME scenarios, there was significant pressure on the classic time-based batch process model for education. While several scenario analyses contemplated a continuous-process medical education model and others saw a hybrid model, all were characterized by a significant blurring of the classic boundaries at each educational transition. In all scenarios, the importance of team-based clinical care will result in a greater need for training and socialization in interprofessional teams during the clinical phase of the education process. While all of the world teams saw that training would be competency-based, it was also clear that new educational structures and approaches will be required. Finally, the approach to GME funding was seen as different in each of the worlds, with considerable uncertainty surrounding its source, level, and consistency.

**Accreditation, Certification, and Licensing**

The roles of accreditation, certification, licensing, and their equivalents vary dramatically across the four scenarios. As a result, the nature of these services will be more fluid and dynamic, with less certainty concerning the continuation of historical models. Finally, in all four scenarios, variability in the demand for these services may require dramatic restructuring of business models. At the same time, the evaluation of learning environments and medical practice will increase in importance. In the future, it seems clear that physician employers, policymakers, and regulators will not tolerate the inefficiencies and confusion arising from a complex multi-actor system with overlapping activities and non-symmetrical approaches to validation/approval. Three of the four scenarios highlighted the need for value-added services to be provided by accreditors and certifiers to those who pay for the services.

**Key Insight Findings**

It would be reductionist to claim that only a few insights generated the new ACGME strategic agenda. Nevertheless, a few key issues appeared over and over as crucial touchstones for the future medical system, education, and accreditation.

- There will be increased complexity in society generally, and patient care specifically, calling for an ever more seamless and disciplined interprofessional team-based approach to health care delivery and medical education.

- There will be increased information transparency, with accompanying challenges to the verification and veracity of competing offerings of data and analyses.
• There was no consensus on the future shape of health care delivery; therefore the maximization of provider career flexibility will be crucial.

• The “commoditization” of health care services accelerated across the scenarios. This turned out to be a very complex and profound phenomenon. It included highly standardized (price-driven) services at entry level, and shifting responsibilities and risks among health professionals in interprofessional team-based care. Surprisingly, it was also seen in former “high-end” procedures that could be rigorously standardized or automated.

• There will be little tolerance for approaches to accreditation, credentialing, and licensing with burdensome process inefficiencies and multiple actors with either conflicting or incompatible standards.

• There was such diversity in medical delivery approaches that the current dichotomous conceptualization of the physicians workforce (e.g., “primary care subspecialist,” “generalist-specialist”) turned out not to be a very useful approach for planning the future of the medical profession and medical education.

• There was no clear optimal specialty distribution across the scenarios (due to the uncertainties and the pace of change exhibited across the scenarios in technological, economic, and societal issues), therefore the medical education system must be capable of supplying a wide variety of distributions of physicians by specialty.

• Combined, almost all of the key insights across the scenarios indicated that there will be profound pressures to de-professionalize all of the health care professions, not just physicians.
ACGME Strategic Agenda

The ACGME is uncompromising in its commitment to the Public Trust. We recognize the importance of our role in strengthening the Social Contract between medicine and the American Public. The ACGME fulfills this role by convening experts from across the nation in all specialties to develop standards, and to monitor performance of programs and outcomes of the graduates. The ACGME’s leadership role must be exercised in a form that welcomes effective input and collaboration from the medical profession, other health professions, and the public, yet with the freedom to make and implement potentially controversial policies and standards that are necessary to achieve its Public Trust-related responsibilities. Our ultimate Mission is to improve the health and health care of the public through enhancement of physician skills; we recognize the importance of accountability to the public for the effectiveness of that effort.

The Public Trust as a Central Feature of ACGME’s Strategy

The ACGME’s commitment to the Public Trust determines how we define our mission, our values, and our strategies, and how we interact with society. We fulfill our component of the Public Trust through effective oversight of the preparation of the next generation of physicians. We will work to ensure that the public can have trust and confidence in all graduates of ACGME-accredited residency programs by:

- Focusing all efforts on the safety and quality of care rendered to patients today and tomorrow;
- Assuring that graduate physicians demonstrate clinical excellence and professionalism;
- Basing accreditation standards on evidence, wherever possible, anticipating the future needs of the public;
- Maintaining confidentiality of individual information and certain elements of accreditation information; and,
- Limiting our collaborations to relationships that are consistent with our commitment to the public and the profession.

The ACGME Mission

We improve health care by assessing and advancing the quality of resident physicians’ education through accreditation.

The ACGME Vision

We imagine a world characterized by:

- A structured approach to evaluating the competency of all residents and fellows;
- Motivated physician role models leading all GME programs;
• High quality, supervised, humanistic, clinical educational experience, with customized formative feedback;
• Clinical learning environments characterized by excellence in clinical care, safety, and professionalism;
• Residents achieving specialty-specific proficiency prior to graduation;
• Residents prepared to become Virtuous Physicians who place the needs and well-being of patients first.

We accomplish our Mission guided by our commitment to the Public Trust and the ACGME values of:

• Honesty and Integrity
• Excellence and Innovation
• Accountability and Transparency
• Fairness and Equity
• Leadership and Collaboration
• Stewardship and Service
• Engagement of Stakeholders

The ACGME strategic agenda that follows cannot be viewed in isolation. Rather, it must be interpreted in light of the ACGME’s philosophy and commitment to the Public Trust outlined above, and our continued commitment to excellence in accreditation of educational programs. Our strategic intent is guided by these principles:

Medical education must:

• Be outcomes-oriented and evidence-based, wherever possible;
• Be forward-facing and improvement-oriented;
• Be responsive to societal needs;
• Anticipate the needs of the public;
• Promote effective interprofessional team-based care;
• Result in graduates who provide for and promote safety and quality of patient care throughout their careers; and,
• Result in graduates who manifest professionalism and effacement of self-interest to meet the needs of their patients.

New Strategic Directions for the ACGME

The following presentation contains the strategic initiatives to be undertaken by the ACGME. There are specific supporting strategy statements and early implementation steps that are not included here for the sake of clarity and brevity.

I. Preparing the Profession to Meet Future Public Needs
Strategic Directions:
The ACGME will proactively guide programs to effectively prepare physicians for the provision of health and health care delivery for the American public.

The ACGME will systematically anticipate the evolving role of physicians in meeting the health care needs of the public. This includes participation in workforce planning, if invited by the government.

The ACGME will explore and incorporate proven emerging technology in education and clinical care delivery.

The ACGME recognizes the need, and will work with others to promote, career flexibility and physician re-entry and retraining, as the health care needs of the population evolve.

The ACGME will continue its efforts to ensure physicians are educated to provide outstanding and safe clinical care, while recognizing the need to enhance competency in communication skills, professionalism, leadership, systems-based practice, patient engagement, and practice-based learning and improvement (among many other cross-specialty competencies).

Illustrative Desired Outcomes:
Physician education across the specialties is consonant with the best understanding and analysis of future patient needs.

Faculty development and resident physician training continuously incorporate new knowledge and technological advances.

The U.S. enjoys an appropriate number, specialty mix, and geographic distribution of physicians to meet the needs of the public and the health care delivery system.

Physician clinical care delivery is more responsive to patient needs due to the ability of physicians to make necessary career transitions.

Public concern over physician acquisition of the “new competencies” no longer exists.

II. Pursuing Knowledge Development in Medical Education
Strategic Directions:

The ACGME will engage in efforts to create new knowledge that enhances the competence of graduates and their effectiveness in the provision of safe and high quality patient care.

Illustrative Desired Outcomes:

ACGME research and ACGME-sponsored research have a reputation for excellence, leading to a sophisticated understanding of physician competence and the influence of the learning environment on physician development.

The ACGME systematically incorporates educational clinical performance parameters shown to be associated with excellence in clinical practice into accreditation standards and processes. GME educational outcomes and (ultimately) patient care and safety are measurably improved as a result of these efforts.

III. Harmonizing the Continuum of Medical Education

Strategic Directions:

The ACGME will play a strong partnership role in improving physician education across the educational continuum from undergraduate medical education to continuing medical education.

The ACGME will convene discussions related to competition, facilitation of transitions along the continuum, and promotion of faculty expertise and development.

Illustrative Desired Outcomes:

Fully compatible and mutually reinforcing accreditation standards and processes have facilitated learner movement through the educational continuum, thus improving educational outcomes.

Physician movement along the continuum of medical education is seamless, based on the level of individual competence (gauged against national standards), and facilitated by effective communication and continuous improvement of the Public Trust institutions of medicine.

The faculty members of ACGME-accredited educational programs are well grounded in the foundational theory and effective in the implementation of competency-based frameworks to meet the future medical needs of the American public. This is in great part due to the clinical learning environment.
within which the faculty members function, where performance is systematically evaluated, valued, and rewarded.

**IV. Enhancing Interprofessional Team-based Care**

**Strategic Directions:**

The ACGME will work in collaboration with organizations that accredit the education of other members of the health care team. Our mutual goal would be to improve interprofessional teamwork among all of our graduates in order to enhance the safety and quality of clinical care.

**Illustrative Desired Outcomes:**

In circumstances where it has been demonstrated to improve patient outcomes and safety, interprofessional team-based care is considered the standard for clinical practice.

Physicians regularly and effectively working in established and dynamic interprofessional team-based care settings have improved quality and safety of patient care.

**V. Increasing Engagement on Behalf of the Public**

**Strategic Directions:**

The ACGME will continue to be a trusted authority on the future roles of physicians and physician education, providing societal value to the public and a broad range of stakeholders. The ACGME views this as an essential dimension of its responsibilities within the Social Contract.

**Illustrative Desired Outcomes:**

ACGME research and advice are sought and valued for important decisions concerning the future of GME in the context of the changing health care environment.

The public and key stakeholders appreciate the societal value delivered by the ACGME.

**VI. Preparing the ACGME for the Flexibility and Adaptability it Will Require**

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Strategic Directions:

Organizational and governance strategies will initiate and/or sustain the following:

- The ACGME’s position in maintaining the Public Trust and the professional ethics of medicine, while applying sound business practices.
- The adaptability and flexibility required to implement the previous strategic agenda, while maintaining the ACGME’s core functions.

Illustrative Desired Outcomes:

- The ACGME is widely recognized for the quality and continuous improvement of its evidence-based standards and processes, the integrity of its decisions, the transparency of its policies and procedures, the stewardship of its resources, and the quality of its services.
Free Markets Unchained

<table>
<thead>
<tr>
<th>U.S. Economy Vitality</th>
<th>The Social Contract</th>
<th>Type of Change</th>
<th>Health Care as a Percentage of GDP</th>
<th>Globalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Limited or Exclusive</td>
<td>Revolutionary</td>
<td>Decreasing</td>
<td>Militarily isolationist, but U.S. economy engaged globally</td>
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Brief Introductory Summary

The United States is a less divided country than it was back in 2013. Libertarian conservative policy has won the day, politically. While economic inequality has actually increased by many measures, most people feel that things are getting better and that they and their children have an opportunity to better themselves. The great release valve has been technological advance, which has transformed the entire economy and society, and has to some extent democratized education and professional credentialing. A stubborn underclass does not reap the benefits of the new techno-meritocracy, but for the vast majority of Americans life is finally getting better.

The road to this end-state has been bumpy. For two decades, America tried big federal government, with federal taxes and benefits creeping upward as a share of GDP. But the Baby Boom retirements seemed to have finally broken the system, and now power and resources have flowed out of Washington to corporations, states and localities. Stagflation and blighted prospects finally pushed the young (even the majority that were not among the “winners”) to rebel against the increasing size of the state and the seemingly bottomless appetites of the old. Much formerly public infrastructure is now privately owned, federal taxes are lower, and a series of Supreme Court decisions has increased states’ rights to unprecedented levels. The U.S. is a major technology player once again, and sensing, biotechnology, nanotechnology, artificial intelligence, personalized medicine and IT all have contributed to a resurgence in national pride and a general sense of optimism. It helps that the world is a more peaceful place; scholars and citizens argue whether it is the cause or an effect of a retreat from a forward military posture and far lower defense budgets.

This scenario is one of a set of four scenarios, and does not represent an ACGME forecast of the future in any way. This is a hypothetical planning environment for developing and testing strategic concepts. It is not intended to be used alone. © Accreditation Council for Graduate Medical Education and Futures Strategy Group, LLC, 2014.
Boomdoggle

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<tr>
<td>Weak</td>
<td>Limited or Exclusive</td>
<td>Evolutionary</td>
<td>Increasing</td>
<td>Increasing slowly, with spotty global growth</td>
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**Brief Introductory Summary**

It’s not been a great time for the United States, but it’s been worse elsewhere, so despite an internal sense of lethargy and little confidence, America’s fortunes remain (head-scratchingly) the envy of much of the world (at least for now). It’s by no means all doom and gloom. Most citizens are just making do, and there are occasional bright spots in the economy. The brightness however never lasts quite long enough to lift the whole economy, and the principal beneficiaries seem to be wealthy investors, global corporate profits, but mainly, the retired.

An odd bedfellow alliance across the political spectrum, with a shared imperative to secure their health and retirement benefits, led a revolution in U.S. politics, with retirement security (income and health care) as the top political priority. The “retired” are now called SAs, (a term shortened from Senior Americans). The acronym is said as one word and often appears in new word combinations (seldom positive): SA-greed, SA-power, SA-life, etc.

Although it is a system no one set out to develop, we have become a nation that pundits have called a self-licking retirement ice cream cone. Most of us live to retire, and the economy works to keep a retirement system in place. It would be easy to blame the Baby Boom, but the reality is that the events and decisions that led us to this place were multi-sourced and incremental. While massive global corporations dominate the economy (and a few do quite well), most Americans are apathetic and focused on just getting by.

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Cloudburst

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<tr>
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**Brief Introductory Summary**

The world has been thrust backwards several decades in many respects by a meltdown of networked communications, the Internet, and global financial networks. The initial crisis, apparently caused by an attack by anarchist hackers, made it impossible for a number of global money-center banks to determine who had what in the way of deposits; this caused a seizing up of the world credit system, and forced the U.S. federal government (among others) to step in and guarantee the credit of almost every actor in the economy. This worked to essentially flatten out the wealth and income distribution a great deal, since the vast majority of financial instruments were owned by the wealthy, and their value plummeted in the ensuing depression, with a 12 percent contraction in the first year after the initial attacks. Since then, government has remained a constant presence in the economy, providing employment and a broad safety net to the poor and middle classes. The economy still faces strong headwinds, because it had been optimized to a world of “anything, anytime, anywhere” on-line commerce and instantaneous communication, much of it dependent on the Internet. Now individual Internet-linked computing/communications devices must be “dumbed down” – or disconnected – to prevent hacking. This includes literally tens of billions of embedded sensors in virtually everything: computers, transportation vehicles, smart electrical grids, smart materials, 3D printers, homes, dogs, and even human beings. And the attacks, though beginning with anarchist hackers, have been continued by thousands of other actors, known and unknown, from nation-states to terrorist organizations to pure criminals to disaffected teenagers. There has been some reconstruction of some of the functionality of the Web, and technological progress continues apace in non-Internet-linked areas, but our world is far short of the techno-paradise we once thought inevitable.

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**There’s an App for That, Too?**

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**Brief Introductory Summary**

The United States is on the move again in a prolonged period of growth that began in the late 2010s. Its most distinctive characteristic is the UIC (University-Industrial Community). Earlier university/private industry/government partnership experiments have emerged as a new business model and produced an array of amazing new technologies, industrial processes, and even social experiments. The UIC concept is spreading across the globe rapidly, if unevenly, and the U.S is once again leading world change.

Computing advances have been a catalyst for better optical wireless networks with almost unlimited bandwidth, nanotechnology, new materials in semiconductors, filters, structures (including morphing structures), bio-genetics, and general simulation and modeling. Robotics and remote-controlled devices are pervasive and have eroded a number of specialties, while giving rise to whole new occupations and professions.

The strength of the economy has allowed a balanced budget, and spending increases to repair a long-neglected infrastructure. But the economic bonanza may be masking fundamental challenges. New technologies always raise new questions, but the sheer scale of change is stretching our philosophical capacity. For some, life’s increasing complexity has eclipsed their ability to cope, and it seems that inequalities between people, professions, industries and countries may widen in the future. Meanwhile, life is pretty good, confidence is high and the American dream is alive and well.

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