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Teaching Health Care Policy: Using Panel Debate to Teach Residents About the Patient Protection and Affordable Care Act

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Abstract

Introduction: The debate format has been infrequently used in resident education. We used the panel debate format as a tool to improve health care professionals' knowledge of the Patient Protection and Affordable Care Act (PPACA). **Methods:** Six physical medicine and rehabilitation resident physician debaters led a 60-minute panel debate about the PPACA. Outcome measures included a survey of the spectators with validated questions on physician attitudes towards health care reform in the US and open-ended questions regarding Americans' views on the US health care system. **Results:** Twenty-nine physician and nonphysician faculty and staff participated as spectators. Responses to the questions on attitudes toward reform of the health care system indicated that zero spectators rated the current US health care system (i.e., the PPACA) as "Excellent," 25% rated it as "Good," 42% "Average," 25% "Poor," and 8% "Failing." Half of the respondents indicated they support a US president who advocates making the US health care system more like those of other countries. The majority of respondents (89%) expressed the idea that the US does not have the best health care system in the world. **Discussion:** Approaching a topic as broad as health care reform with the debate format promoted knowledge, reflection, and interaction with both the opposing debaters and audience.

Keywords

Rehabilitation, Debate, Health Care Policy, Health Care Professional, Hospital Physician, Patient Protection and Affordable Care Act

Appendices

- A. Topics Used to Guide Resident Preparation.docx
- B. 10-Question PPACA Knowledge Pre- and Posttest.docx
- C. Sample Introduction to Current State of Health Care.pptx
- D. 3 Questions on Attitudes Toward US Health Care .docx
- E. 8 Open-Ended Questions About US Health Care Reform.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this session, learners will be able to:

1. Identify resources to prepare a 5-minute introduction on the current state of US health care.
2. Prepare a 10-minute summary on the changes being proposed within health care law.
3. Recognize the six major stakeholders within health care reform and work as a team to evaluate and defend the effects of new laws upon each.
4. Develop critical thinking abilities that can be applied to clinical interdisciplinary team meetings.

Introduction

Education regarding current and new health care policy is important, as most resident physicians will soon practice under these laws. However, a review of the literature does not support an effective method to teach health care management or national health care delivery within the structure of the standard residency educational format. This format has traditionally included didactics, conferences (e.g., grand rounds), bedside teaching, procedural oversight, and specialized workshops as standard pedagogies. In

alignment with the ACGME strategic priority to foster innovation and improvement in the learning environment of resident physicians,¹ we decided to explore the use of debate to teach resident physicians.

Throughout history, debate has been used as both a communicative and an educational tool. In the movement towards active learning, the use of debate in place of a traditional lecture has been shown to have numerous benefits.² Further, learning occurs more effectively when using a debate format during which analysis, discussion, and application of information skills are utilized.³ A successful debate requires interaction, collaboration, and reflection, combined with an ability to discern and communicate information efficiently.⁴ Debate has been shown to improve oral communication skills through enhanced self-expression, social interaction, and teamwork.⁵ These are all abilities in which physicians must be skilled, and there is some evidence of debate effectiveness in medical education settings at an international level, where debate has been used to teach about women's health, oral health, and ethics.⁶⁻¹⁰ However, there is little evidence of debate being used as a teaching tool during resident education.¹¹

Hypothesizing that the debate format's strengths extend to the professional development of resident physicians, we conducted a small pilot study on the use of debate to teach about national health care. As a result, we demonstrated the feasibility of using a policy debate format in physical medicine and rehabilitation (PM&R) resident medical education.¹¹ To build on this work, we decided to pilot a panel debate. Among the various different forms of debates, the panel debate is the most familiar to clinicians given its similarity to an expert panel discussion. Expert panels typically start with a lecture or series of lectures given by an expert panel, followed by the panel answering questions from the audience. In a similar fashion, the panel debate starts with the two opposing teams of experts providing pro and con arguments for a topic and then sitting together to field questions from the audience. Because of the similarities, we hypothesized that the panel debate would be easily adapted into a residency training curriculum as a conceivable tool for training well-rounded physicians.

The largest health care reform in the US in the past 40 years occurred when the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.¹² Given the nation's divided view of the PPACA, as well as opposing views within our own residency program, this seemed like an important topic for piloting the panel debate format in 2014. While the PPACA is now law, it remains an important topic as there is ongoing debate regarding repealing, replacing, and optimizing it. The literature suggests that US health care reform remains a predominant topic of discussion across specialties in the health care landscape.¹³⁻²¹

To date, neither resident knowledge regarding the PPACA nor the use of panel debate in resident education has been assessed. Therefore, the primary aims of this project were to design a panel debate as a resident teaching tool on the PPACA and to provide a reproducible structure that could be used to study future proposed health care law.

Methods

The debate process consisted of three distinct periods: (1) preparation for the debate, (2) the panel debate plus administration of pre-/posttests and survey, and (3) follow-up. Each component is described below.

In preparation for the debate, the program director approached two residents with the idea of using a panel debate on health care reform to teach the PPACA. Both residents agreed with the potential benefit of this activity, accepted the responsibility to lead the debate as team captains, and assembled their respective three-person debate teams. In identifying team members, numerous residents were found to be eager to research and learn about the PPACA. Ultimately, the two teams were assembled based on passion for improving national health care delivery, willingness to express personal opinion in this format,

and interest in learning about the PPACA. The debate was approved by the local institutional review board and received exempt status.

Both teams received a list of questions (Appendix A), each of which inquired about the effect the legislation might have on one of six major facets of health care reform. The teams met to discuss the six facets and divided them up to research. Given they were three-person teams, each resident selected two facets to research based mainly on his/her personal interest. The residents then conducted their research independently, but teams met frequently to relay information, share resources, and ensure every question was interpreted through diverse viewpoints. Team captains delivered 5-minute presentations on key changes proposed by their teams. Although this increased the captains' time commitment relative to that of the other residents, we believe that the captain's organizing of the thoughts of the entire team during multiple preparatory meetings was necessary in order for all residents to have a good understanding of the proposed changes for an effective debate.

The standard structure of the panel debate was a short lecture followed by a timed debate session. A conference call was held in which the course directors (the PM&R residency research rotation director and the PM&R residency program director) and all six members of the pro and con teams reviewed the debate structure and agreed on the order in which the facets would be discussed.

The 1-hour session took place in a large auditorium with both teams on stage facing the audience. The session began with a 10-question multiple-choice PPACA knowledge pretest (Appendix B) for the audience members. Next, one resident presented a 5-minute introduction on the current state of US health care (Appendix C). This resident volunteered to do so during preliminary meetings and chose to present data on cost per capita, cost as a percentage of gross domestic product, percentage of individuals who cannot pay, physicians per capita, number of hospital discharges, length of stay, diagnostic imaging costs, pharmaceutical costs, access to physicians, and preventable mortality. For this task, Organisation for Economic Co-operation and Development health data enabled comparison between the US health system and those of other countries.²² Additionally, the Commonwealth Fund provided organized charts (e.g., "Multinational Comparisons of Health Systems Data, 2013") and a survey regarding individual access problems.²³ As these data sets and surveys are produced yearly, they were excellent resources for future residents to quickly find pertinent information for the current or historic state of US health care.

Following the introduction, the debate began with each team captain explaining that team's position on the legislation, including the top five to 10 proposed changes, along with a brief expansion on the perceived result of such changes. Each team then had 2 minutes to discuss the effects of the legislation on each of the six facets (24 minutes total) in the following, agreed-upon order:

1. Small businesses.
2. Public and private institutions.
3. Individual Americans.
4. The American economy.
5. Individual physicians.
6. American health care.

After this, the audience had 10 minutes to ask questions of the panelists. The audience was made up of faculty physicians, resident physicians, as well as medical students, nurses, social workers, case

managers, administrators, and therapists. A convenience sample of audience members was composed of those who responded to email and poster advertisements distributed throughout the hospital.

The final 5 minutes of the session were used for audience evaluation. The evaluation was threefold. The first component was a posttest knowledge survey identical to the pretest (Appendix B). Pre-/posttest questions were developed by a separate subgroup made up of the program director and a research assistant not involved with the actual debate, to avoid any undue influence on the participants. The subgroup reviewed the PPACA and any current associated public reports.¹² The pre-/posttest questions subgroup then created 10 questions that were geared towards testing general concepts of the PPACA. The second evaluation component was a three-question survey with validated questions on physician attitudes towards health care reform in the US (Appendix D).²⁴ The third evaluation component was an eight-item open-ended questionnaire (Appendix E) regarding Americans' views on the US health care system, adapted from the Harvard School of Public Health and Harris Interactive study on health policy issues in the presidential debate.^{12,24-26} Due to time constraints, participants were permitted take the open-ended questionnaire with them to complete at a later time. A location for confidentially returning responses was set up by the residency program administrative assistant.

Data Analysis

Data on the multiple-choice questions are displayed as means and percentages. Raw data are reported for the participant responses to the open-ended questions. Because of the small sample size, we did not perform any statistical testing. The present data are preliminary and should be used only to explore the usefulness of the panel debate format to educate about PPACA in resident education.

Results

The debate was held on May 9, 2014. The audience consisted of PM&R physician and nonphysician faculty, PM&R resident physicians and medical students, as well as PM&R nurses, therapists, social workers, case managers, and administrators. Out of the 14 residents in the PM&R residency program, 11 (79%) were present for the debate, including the six residents who actively took part. Of the three residents not present, two were working offsite, and one was on paid time off.

PPACA Knowledge

Of the 24 audience members, 22 (92%) completed the PPACA knowledge pretest, and 19 (79%) completed the posttest (Appendix B). The percentage of respondents selecting the correct response increased from pre- to posttest on seven of the 10 questions (Table). The percentage of correct responses (mean $\pm$ standard deviation) on the PPACA knowledge test was $55.4\% \pm 19.7\%$ for the pretest and $60.4\% \pm 23.2\%$ for the posttest.

PPACA Attitudes

The three-question instrument (Appendix D) showed that the majority of respondents (92%) were "somewhat informed" about the PPACA but had differing attitudes toward it. When asked to rate the current US health care system (i.e., the PPACA), 42% of participants rated it as "Average," 0% rated it as "Excellent," 25% as "Good," 25% as "Poor," and 8% as "Failing." When asked about their overall opinion of the PPACA, 33% of the respondents believed the PPACA was "a good start," while 25% believed the PPACA was "a step in the wrong direction." The remaining respondents indicated they "don't know" what their overall opinion was.

Table. Participant Responses to Pre- and Posttest Multiple-Choice Questions About the Patient Protection and Affordable Care Act

Question and Choices	No. (%)	
	Pretest	Posttest
The Secretary of the Health Department shall make available performance information and summarizing data, to anyone wishing to view it, by way of:		
a. Bi-weekly emails to practicing physicians	1 (5)	—
b. Monthly letters to subscribers	1 (5)	—
c. Internet websites	17 (77)	17 (89)
d. Telephone hotlines	3 (14)	2 (11)
A group health plan and a health insurance issuer offering group or individual health insurance coverage plan:		
a. Is required to be purchased by all citizens	7 (32)	5 (26)
b. Should only be given to taxpaying citizens	—	—
c. Is free to any citizen of the US	—	—
d. May not exclude any pre-existing condition	15 (68)	14 (74)
Each health insurance issuer that offers health insurance coverage (to individuals or groups) in a State must accept every employer or individual in that State who:		
a. Donates to the State's health care fund	3 (14)	2 (11)
b. Conducts business in the State	5 (23)	5 (26)
c. Applies for coverage	12 (55)	12 (63)
d. Receives permission from the Secretary of Health	2 (9)	—
Any agency offering health coverage shall not issue waiting periods greater than:		
a. One month	7 (32)	6 (32)
b. A fiscal year	—	1 (5)
c. The amount of time since last insured	—	—
d. 90 days	15 (68)	13 (63)
What group is responsible for educating primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services?		
a. The Elderly Assistance Initiative	—	—
b. The Primary Care Extension Program	17 (77)	17 (89)
c. The Secure Appropriations Board	3 (14)	—
d. The Secretary of State	2 (9)	2 (11)
The group in charge of creating a preventive regimen (diet, exercise, prescription calendar, etc.) for each individual is the:		
a. Customized Prevention Process Agency	5 (23)	5 (26)
b. Family Care Planning Initiative	3 (14)	1 (5)
c. Personalized Prevention Plan Services	13 (59)	13 (68)
d. Distributive Planning Measures Collective	1 (5)	—
A physician who has received training in an accredited medical specialty, sub-specialty, surgical specialty, residency, or fellowship institution is:		
a. Resident Doctor	3 (14)	2 (11)
b. Appointed Medical Expert	7 (32)	5 (26)
c. Qualified Health Professional	12 (55)	12 (63)
d. Nurse Practitioner	—	—
Health related tasks, according to state law, must be carried out by:		
a. An attendant	2 (9)	2 (11)
b. A doctor	7 (32)	5 (26)
c. The individual	11 (50)	9 (47)
d. The Surgeon General	1 (5)	3 (16)
Private health insurance agencies shall not be subject to Federal or State mandates with regards to:		
a. Criminal offenders	11 (50)	5 (26)
b. Judiciary systems	1 (5)	2 (11)
c. Market conduct: privacy and confidentiality	6 (27)	6 (32)
d. Educational institutions	3 (14)	6 (32)
In regards to insurance premiums, the maximum amount an 18 year old applicant may be responsible for is half of the policy year's value:		
a. True	4 (18)	3 (16)
b. False	18 (82)	16 (84)

Correct responses are in bold.

The open-ended question survey (Appendix E) was returned by 10 individuals, who responded to the questions with the following:

1. Do you think the US has the best health care system in the world?
 - “We have a lot of options. However, we need to control costs & spending. We need more help from individuals to be healthy and to understand their role in their own lives.”
 - “Probably has the best medical technology and education in the world, However, our access and outcomes are seriously lacking. This case, which is difficult to access and has poor outcomes, is also very expensive.”
 - “The numbers speak for themselves. Our system is the most expensive by far yet yields mediocre outcomes.”
 - “Cost is too high with outcomes too low.”
 - “We spend too much money per patient with worse care than some other industrialized nations.”
 - “No, too expensive for below average care.”
 - “All available information says no.”
2. Do you support a US President who advocates making the US health care system more like that of other countries? Yes or no?
 - “Yes, if it would actually work.”
 - [Yes] “We must be willing to learn from those who have better systems.”
 - “Yes and No—a modified version of existing systems may work.”
 - “Yes, if these systems are successful.”
 - [Yes] “We should learn from other countries, when possible, to improve our system.”
 - [No] “Not really sure we are ready for that. It would limit options. Americans want tests & high cost procedures other countries don’t necessarily offer.”
3. What have we (the US) gained by changing to the current health care system?
 - “Cost awareness.”
 - “Remains to be seen.”
 - “Hasn’t really changed yet.”
 - “Coverage for more people.”
 - “Nothing.”
 - “More coverage for more people. Helping people pay for insurance with subsidies.”
 - “Quieting the masses.”
 - “The best thing we have gained is that individuals with pre-existing conditions are not left uninsured. Everything else remains to be seen.”
 - “More people working the system.”
 - “Nothing, more bureaucracy.”
4. What would we lose by changing away from the current health care system (PPACA)?
 - “Not sure we can move away from it.”
 - “Physician autonomy and pay.”
 - “Money invested already.”

- “Nothing.”
 - “Education suffers. Kindergarten through 12th grade and college.”
 - “Progress.”
 - “More uninsured individuals who go to Emergency Departments for primary care.”
 - “The few good aspects that are in place.”
 - “Lots of wasted [money] and time. I think ACA is a big mistake.”
5. What should be the role of the federal government in the health care market?
- “Minimal.”
 - “Regulating.”
 - “Develop a system that works.”
 - “To help with health care cost.”
 - “It is inevitable that the federal government will be involved with the new laws. I believe physicians should always be consulted in conjunction with the federal government.”
 - “Regulation, to make sure individuals are treated fairly and not being taken advantage of by insurance companies.”
 - “Minimal.”
 - “Supply basic care.”
 - “If they want to reimburse health care providers for all their charity care, the people that they are trying to force to buy healthcare will continue to need charity care.”
6. Who should regulate the health care industry in the US?
- “Unsure. The surgeon general?”
 - “Government but with input from medical providers.”
 - “Care of patient.”
 - “Some physicians with business degrees and advanced business knowledge.”
 - “Federal government.”
 - “Federal government.”
 - “The people.”
 - “Not government.”
7. How should questions of overall system effectiveness (efficiency, quality of health care, access and sustainability) be addressed for universal coverage?
- “Unsure.”
 - “I guess Electronic Medical Records will help with effectiveness ratings.”
 - “I don’t know.”
 - “Insurance companies who provide the most comprehensive and efficient programs should become models for that set the standard for the rest. Federal Govt. should provide the statistics as to how the companies are performing.”
 - “By how we rate with other countries.”
8. What are some of the impediments to implementing US health care reforms?
- “Lack of doctors [and] number of young people enrolling.”
 - “Cost to middle class.”
 - “State level legislation.”

- “Unrealistic expectations. We need multi-tier system but people promote delusion of equality.”
- “Mandating Americans to buy a ‘product’—political parties constantly obstructing progress—size of the system and the US—complexity of US health care system.”
- “It is not enforceable. Maybe if they want to become Big Brother they could enforce it. Enforce border patrols.”

Not all questions were responded to by all participants, but a general sense of where the group of health care professionals stood on these questions could be gleaned. For example, the majority of the respondents thought the US did not have the best health care system in the world and indicated that they supported a US President who would advocate making the US health care system more like those of other countries. Similarly, the majority of respondents did not feel the US had gained much through the PPACA and therefore did not seem to agree on one thing that would be lost by moving away from the PPACA, except money, which was mentioned by three respondents. The remaining four questions regarding health care regulation, quality measurement, and implementation had even less agreement among respondents.

Discussion

Research has shown the debate process can be used successfully as a teaching tool in many health care–related professions, including nursing, dentistry, psychology, and sociology.²⁷ Debate is recognized as a technique for actively engaging students in mastering content, developing their critical thinking skills, and communicating their thoughts effectively.^{3,5} Generally, our participants enjoyed the process of researching and performing a debate.^{3,4} A recent study found that medical professionals in fellowship training agreed that actively participating in the debate process was not only enjoyable but also thought-provoking and beneficial to self-learning.²⁸ Among a sample of urologists, educational benefits have been shown even for audience members, who were not actively engaged in the debating process.²⁹ To the best of our knowledge, our study is not only the first to report the use of a panel debate to teach about the PPACA, but also the first to evaluate the use of a panel debate in physician residency training.

Panel Debate for Resident Development

There are multiple tools to develop residents’ knowledge base with regard to medicine, but we felt there was a dearth of learning experiences designed to enhance residents’ critical thinking skills, their ability to publicly defend an idea, and ultimately their leadership development. Debate is an active learning tool that fills this gap and, when used correctly, is well received by residents.

Our pilot policy debate on health care reform found residents to be apprehensive about sharing personal views on US health care, but the current sample enthusiastically accepted the debate format. Several postulates could explain this change in the residents’ attitude.¹¹ Although the policy debate structure is distinctly different from the panel debate structure, the original debate served the function of familiarizing the program’s residents to debate as a pedagogical tool in residency training. This is a very important point for any program contemplating the use of debate as a teaching tool. The more a tool is utilized, the more the learner becomes comfortable with it. Another possible explanation is that panel debate is very similar to panel discussion in grand rounds, a frequently utilized teaching format in medical education. Although the panel debate has not been formally evaluated as a teaching tool in residency training, the familiarity of its structure could have assisted in making the residents less apprehensive. The final possibility explaining the change in attitude has to do with self-determination. The original groups of debaters were randomly assigned to pro and con teams, whereas this group’s debaters were allowed to choose which team that they wanted to represent. Furthermore, policy debate is arbitrated by an independent judge, whereas our panel debate was self-governed by the participants. These allowances empowered the residents to take control over the information they wished to learn and therefore ownership of their own learning.

Clinically, we feel the placement of panel debate within in a graduate medical education program is justified as it mimics not only grand rounds but also daily interdisciplinary team meetings where multiple ideas and positions are brought forward and residents have to balance each perspective with what is best for the patient. When meeting with residents and guiding them through this process, it is paramount that the facilitator nurture a mind-set for seeing the facts as they are, rather than merely collecting those facts that support a preformed theory. A possible change in future studies would be an introductory learning period requiring residents to collect data supporting both sides of their chosen topics before deciding which side to publicly defend. Emphasis should likewise be placed on collaboration and compromise rather than simply on good versus bad or winning versus losing. In this light, we find debate to be a useful developmental tool whether the topic is policy reform or a variety of other highly controversial topics, such as the following:

- Commercial support of continuing medical education.
- The percentage of babies that should be born by caesarean section.
- The ethicality of providing elderly people with drugs that will improve longevity and mortality.
- Opioid use in the management of postsurgical pain among patients with known addictions.
- Drug pricing.
- Immigrant health.
- Health care entitlements.

Panel Debate Impact on PPACA Knowledge and Attitudes

We feel that the PPACA is well suited for debate given the past and current political and emotional discourse surrounding this complex piece of legislation.^{20,21} In this tumultuous climate, the use of debate reduces potential bias of the instructor.³ Additionally, by hearing and considering multiple viewpoints on health care reform, both the audience and the debate teams develop empathy for another's views, even those with polarizing content.⁵ Finally, a topic as broad as the PPACA (and, undoubtedly, future health care legislation) remains difficult for a resident to research and teach individually. By working in teams and breaking the topic into multiple segments, residents were able to learn more about specific pro and con facets of the PPACA, as well as how to collaborate with team members on other segments. In listening to others and in teaching their topics during the debate, residents further solidified their understanding of the PPACA.

Due to the small sample size, the 5-point increase in PPACA knowledge from pre- to posttest is not statistically significant; however, the residents' achievement of topic matter expertise is reflected in their willingness to debate this complex topic for an hour in front of a large audience. In the weeks after a debate, program leaders should watch for further self-directed learning on the topic, the ability to abstract truths and exceptions in similar and nonsimilar topics, and use of the constructs of debate preparation to approach other multifaceted discussions with an open mind by acknowledging multiple perspectives.

Beyond just the residents, the panel debate also introduced a complex topic to 29 other health care staff, including faculty physicians, medical students, nurses, therapists, and administrators. In terms of this audience, the topic of the PPACA was justified in that not one respondent reported feeling "very informed" about the PPACA, despite the sample being composed entirely of health care workers. A higher percentage of audience members responded correctly on the posttest following the presentation, despite the debate not focusing specifically on those questions. This result is consistent with a prior study in which urology-specialist audience members improved their correct response rate and further acknowledges the potential utility of the debate process as a learning tool even for those not actively debating.²⁹

Lessons Learned

The majority of respondents (92%) believed they were somewhat well informed about the PPACA, consistent with the study by Keckley, Coughlin, and Gupta in which 71% of respondents reported being "somewhat informed" about the PPACA.²⁴

A quarter of respondents (25%) characterized the current health care system as "a step in the wrong direction," and 75% indicated the health care system was average, poor, or failing. The majority of

respondents (89%) felt that the US did not have the best health care system in the world. Additionally, half of the respondents indicated that they would support a US President who advocated making the US health care system more like those of other countries. Although specific responses to the open-ended questions varied (Table 2), our results are consistent with a 2011 Deloitte study on physician perspectives about health care reform and the future of the medical profession, which found that 60% of the 501 physicians queried rated the PPACA as average, poor, or failing.²⁴

Limitations of the Panel Debate Educational Intervention

This study is not without limitations. Data regarding perceptions of the debate format or the use of debate as an educational tool were not collected from the residents who participated in the debate. After the debate ended, several residents commented that they enjoyed the process of thoroughly gathering information and communicating it to a rapt audience. These individuals expressed interest in approaching complex topics by way of debate in the future. Our residents also expressed a preference for active learning styles as a means of moving beyond basic knowledge, which provides a unique opportunity for topics only infrequently taught.

To maintain confidentiality and optimize the integrity of the answers, resident participant characteristics such as years in residency, age, and political affiliation were not identified in the surveys or the pre- and posttests. Therefore, stating that residents specifically improved in response rate is not possible with this study. Similarly, to promote participation, resident characteristics were not identified for open-ended question responses either, and thus, no data specific to residents can be extrapolated.

Future Perspective

The panel debate format used to teach the PPACA created a spirited atmosphere in which residents approached a complex policy using an engaging and active learning strategy. Using this format introduced a broad and complex subject, increased interaction and development of empathy for opposing views, and decreased bias on a polarizing topic. We conclude that panel debate can be an effective tool for teaching broad, controversial topics in an enjoyable and engaging manner. Additionally, we feel the structure outlined above can easily be adapted to new policies/legislation, and can serve as useful adjunct to graduate medical education and to the teaching of topics other than those related to policy or politics.

The recommended time commitment for future debate preparation includes 2 hours for a single resident (volunteer) to prepare slides on the current state of health care, 6 hours of research for each panelist (3 hours per topic), and 2 hours for each team leader preparing the summary of proposed key changes to the legislation. The program director and research assistant require a commitment of approximately 3 hours each to develop a 10-question survey, but this could be significantly less if the individuals selected for the task are already familiar with the legislation. An ideal preparation period should last 1 month, with three panelist meetings at the ends of the first 3 weeks and the debate taking place after the fourth week.

Future studies could evaluate other types of debate for use in residency training curriculum. For the purpose of proving utility regarding health care reform education, combining a study such as this with a traditional faculty-level lecture could provide useful evidence to support debate integration. Also, sampling size could be improved through utilization of multicenter evaluations, and questionnaires could be optimized for evaluation of both knowledge and resident satisfaction. Further studies could also evaluate how the policy debate and the panel debate might be utilized to teach topics less broad but requiring interdisciplinary management, such as preventive health care or patient education and compliance.

We hope this resource will inspire hospitals to adopt the use of debate as an educational teaching and learning tool in residency training programs.³⁰ This hope is tempered by the fact that historically, resident physicians have rarely participated in teaching about health care policies or comprehensive health care delivery.³¹ Scholars argue that this creates a divide between the major stakeholders in the US health care system: practicing physicians, other health care professionals who aid in creating the health care structure, and policy makers.^{32,33} To bridge this divide and improve health care delivery, future physicians ultimately must learn—and practice—medicine based on current and future regulations.

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Prior Presentations

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Ethical Approval

Reported as not applicable.

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