As family medicine educators and practicing clinicians, we are frequently asked to teach learners from varying disciplines and levels of training in our family medicine practice sites. Though this activity may hinder our ability to provide efficient and patient-centered medical care, teaching medical students and family medicine residents has traditionally increased our professional satisfaction as we are directly involved in the education of the next generation of physicians. This participation in their training gives us the opportunity to improve the quality of care they will ultimately provide and make a positive contribution to the health care system and society.

The presence of other learners such as nurse practitioners and physician assistants may also provide the same professional satisfaction, but providing clinical education for this group of learners may also interfere with the education of medical students and residents. Furthermore, providing nonphysicians with the same educational experience as medical students and residents might be detrimental to the overall health care system and our discipline if such education results in the perception of similar experience and skills. These competing demands may have significant negative consequences if a thoughtful and reasoned approach is not taken. As family physicians, should we work with our colleagues from other professions to develop learning experiences for nonphysicians that allow them to excel in their role on the health care team without being perceived by some to be the equivalent to the training of a family medicine physician?

Historically, the training of medical students and family medicine residents is an integral and familiar aspect of our professional activities and fairly well standardized by national accreditation bodies. Family physicians are extremely familiar with medical school and residency training and easily incorporate these educational aspects of physician education into their daily work activities. Furthermore, medical students and residents represent the next generation of physicians and colleagues that we have sworn to train as part of our Hippocratic Oath and may eventually choose family medicine as their discipline and our practices as their future site of professional activity.

On the other hand, family physicians are less familiar with the optimal approach to training nurse practitioners and physician assistants in the family medicine setting. As noted by Shaffer, the education of medical students and residents is fairly standardized due to the oversight provided by national accreditation bodies. Similar national standards are not established for graduate nursing programs, and there is no equivalent national accrediting body like the Accreditation Council for Educating Nurse Practitioners and Physician Assistants in the Family Medicine Practice: We Need a Thoughtful and Focused Team-Based Approach

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for Graduate Medical Education (ACGME) for such programs. As such, the specific educational experience in the clinical setting of a family medicine office may not be consistent with their future roles on a primary care team.

From a family medicine perspective, our discipline should work with schools of nursing and physician assistants to provide a reasoned and standardized approach outlining how to best educate these providers in a primary care environment. As the basis for creating an excellent and appropriate educational experience for nonphysician providers in family practices, the current model for the delivery of primary care based upon a team-based care approach is fundamental. A health care team is a group of individuals with a certain level of diversity working within the unique skills and experience of each team member for the betterment of the patient and the community they serve. The specific educational activities of each team member should be driven by their role on the team. As such, family medicine educators should consider how we provide training to various members of the primary health care team that include not only medical students and residents but also nonphysician students.

For example, the family physician is trained to assess the patient in the context of their family and community, provide a complex differential diagnosis, develop a treatment plan that addresses multiple organ systems and behavioral issues, and order and interpret tests within the context of the patient’s overall health condition (American Academy of Family Physicians, 2012). In contrast, nurse practitioners, physician assistants, and other similar health care providers are usually trained to provide basic preventive care or treatment of straightforward acute illnesses and previously diagnosed chronic conditions that require routine follow-up. As such, the optimal experience for these students might involve participating in activities expected of similar providers in the context of the primary care team. Working directly and exclusively with family physicians might not be the most appropriate experience for such learners.

Nurse practitioners, physician assistants, and other nonphysician health care providers should be trained to fulfill their unique, separate, and important roles on the health care team. The care of patients is best served by multidisciplinary teams where the clinical team is led by a physician as noted in the patient-centered medical home (PCMH) model with specific, complimentary roles filled by other health care professionals, including nurse practitioners and physician assistants. We should not expect or provide a training experience for nonphysicians that is similar or identical to the training experience of a family physician. Diversity of skills and approaches will strengthen teams and allow each discipline to adopt the role best suited for their training. To train otherwise risks unintended professional and economic consequences to the health care system as well as to the discipline of family medicine.

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