The basic structure of a family medicine residency has been undergoing substantial change over the past decade. Four papers in this issue highlight some of these changes. The papers by Carney, Waller, and colleagues\(^1\) and by Young and colleagues\(^2\) describe work done in the P4 (Preparing the Personal Physician for Practice) project. P4 started in 2007 and is now completed. It was a longitudinal case series experiment describing the process and outcome of curricular innovation in 14 residencies across the nation.\(^3,4\) Much has been learned from this experiment; P4 has already resulted in over a dozen publications in this journal alone. More recently, the Family Medicine Length of Training Pilot (FMLOTP) was undertaken to study the utility of lengthening the duration of residency from 3 to 4 years.\(^5\) The lead paper in this issue by Carney, Eiff, and colleagues describes some of the early findings from this work.\(^6\) Finally, we are now beginning a process of unifying the accreditation of allopathic and osteopathic family medicine residencies into a single accreditation system. This ambitious process is fraught with both opportunities and challenges as described by Ahmed and colleagues.\(^7\)

This is a lot to keep track of if you are a residency educator. Residency directors and faculty are busy with day-to-day work and do not always have time to attend national meetings or to read journal articles about lessons learned in other programs. With all that is happening, it is easy to lose track of the big picture. So now is a good time to ask a simple question. What is the fundamental societal purpose of a family medicine residency? Throughout our 50-year history, our goal has been to produce comprehensively trained generalist physicians who can care for people from cradle to grave in any community in America. Even though residencies are sometimes judged by how many of the their graduates enter practice in the same geographic area as the training program, our residency requirements have been designed to ensure that any resident, regardless of where they train, can get the basic skills needed to practice in any community. In an era of rising educational debt and restricted residency work hours, is this goal still relevant or should residencies “specialize” in producing family physicians for specific kinds of communities? How will incorporating osteopathic residencies into a common accreditation system impact our answer to this question?

Consider how the changes in residency education look if you happen to live in rural America. Health care in our most rural communities is heavily dependent on family physicians working in small rural hospitals often without hospitalists, obstetricians, emergency medicine physicians, or specialty backup. If you are practicing in such a place and need a new partner, what percent of the 2017 graduating class of residents from America’s 498 family medicine programs will have the skills needed to cover the emergency department, stabilize the care of people with major traumatic injuries, and care for people with heart attacks without help from on-site specialists? One might argue that practicing in a remote rural community is not in the future for most residency graduates, so perhaps the comprehensive clinical skills required for such practices should be taught in post-residency fellowships. In the future, should rural communities limit their physician searches to the much smaller pool of graduates from such fellowships?

How does this issue appear to medical students and residents? When students choose our field, can they still be confident they will be able to master all of the skills they will need to practice anywhere in the country? The lead paper in this issue by Carney and Eiff sheds
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some light on how young physicians view extended training. Their study examined the attitudes of residency graduates at the time of their certification exam in 2014 and found that about 48% were somewhat or very likely to pursue additional training if it were available. Because the study examined 2014 graduates prior to the onset of the FMLOTP, the vast majority of the subjects in this study had just completed a 3-year residency.8 You can read this paper and conclude that a majority of the graduates were not interested in additional training, but what does it mean that nearly half were interested? How many of these graduates would feel well prepared to practice in rural America after 3 years of training?

Family medicine is now pretty much the only specialty in medicine that adheres to a 3-year residency structure. Internal medicine and pediatrics are still 3-year programs, but a large majority of their graduates enter subspecialty fellowships. Dermatology is a 3-year program, but requires a preliminary rotating internship first. Emergency medicine still has 3-year programs, but their program requirements specifically allow programs to choose between a 3-year and 4-year format and 25% of their programs are now 4 years in duration.8 Family medicine is not becoming easier than it used to be and it is certainly not easier to master than other specialties with longer residencies. Students and residents know this is true.

Family medicine stands at a crossroads regarding the basic goals of a residency in our discipline. Is the goal to produce a graduate who could practice anywhere, or has the goal become more narrow and regional? If we embrace diversity and allow programs to focus on local needs, will the American people know what to expect when they choose a new family physician after moving to a new community? Perhaps there are fewer differences between urban and rural practice than one might think. Even the most rural practices are now using electronic health records. Team-based care with fully integrated mental health needs to become a reality in even the most rural settings. In fact, the shortage of mental health services in such communities makes an integrated model even more important. There is also good evidence that family physicians with more comprehensive clinical skills are more effective in lowering health care costs.9 Most Americans now live in urban areas, so it is hard to imagine how health care costs can be constrained if comprehensive practice only occurs in rural communities. It does not bode well for the triple aim if we allow the new skills required for team based population health care to displace the comprehensive clinical skills needed for rural practice. Now is the time to step back from our day-to-day work and think carefully about our goals. We cannot stand forever at this crossroads. Not choosing is itself a choice.

References