Saultz and David urge us to lengthen family medicine residency to 4 years.¹ As we explore options to energize our specialty, we should also consider the merits of reducing our training to 2 years.

Drs Saultz and David point to three challenges to our current training model, including changing patient populations, pressures on residency education due to expanding educational demands and duty-hour limits, and a shift in the demographics and expectations of our residents. They cite a number of reasons for modifying the length of training. These include addressing the Future of Family Medicine (FFM) report, maintaining a comprehensive curriculum, providing residents with adequate experience, resident and faculty preference, declining interest in family medicine, leading health care reform, and counteracting stagnation in our field.²

Drs Saultz and David have identified major issues confronting family physicians in general and medical educators in particular. Although they conclude that a 4-year residency is the appropriate response to this set of challenges, there are alternative interpretations and strategies.

One way to frame the discussion of the recommendations of Drs Saultz and David is to divide the challenges outlined above into two broader categories: the role that family physicians play in our health care system and recruiting students into family medicine. The FFM report attempts to answer the fundamental question of the role of family physicians.² It notes that patients do not expect or even want us to be all things to all people. The centerpiece of its proposed “New Model of Family Medicine” is the “practice” that will serve as a “personal medical home.”

I agree that the practice is at the core of what family physicians have to offer. We excel at offering comprehensive, integrated services to patients of all ages in ambulatory, office-based settings. While we can proudly claim to be the best prepared by education and training to care for the range of patients and conditions confronted in ambulatory settings and can back up our claim with statistics that demonstrate our dominant position in this arena—we need to choose our words carefully when we discuss our role providing hospital-based and labor and delivery services.³ The FFM report tiptoes around this issue by placing deliveries and hospital care in its basket of services but noting that this requirement can be met by offering “seamless” transitions between the practice and the physicians (not necessarily family physicians) who actually provide the inpatient care or perform the deliveries.

Drs Saultz and David acknowledge that fewer family physicians now offer hospital and delivery services, but they use this point to argue for extending training. A 2-year curriculum for family medicine has been proposed.⁴ Two-year residencies can and should continue to provide inpatient and obstetric experiences, but their curricular weight should reflect the diminishing number of graduates who incorporate these services into their practices. I agree with Drs Saultz and David that family medicine should provide opportunities for greater depth of training in particular areas of focus, but this also can be accomplished in the context of a 2-year residency. We can offer, not mandate, a range of 1- to 2-year additional training options commensurate with the breadth of family medicine itself. These options could encompass the certificates of added qualification already offered, as well as fields such as obstetrics, urgent/emergent care, and research.

We should define the expectations of our graduates by focusing on primary care services in ambulatory settings in a 2-year residency. This would have the added benefit of addressing a key FFM finding: patients don’t know who we are or what we do. A 2-year program would not preclude us from staying current. A comprehensive understanding of medicine could still be taught that incorporates newer principles noted by Drs Saultz and David, such as evidence-based medicine and continuous quality improvement, but the training would be in the context of the realistic

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¹ Saultz AM, David KM. FAMILY MEDICINE. J Fam Pract 2005;54:737-41.
expectations patients and payors have of family physicians providing services in ambulatory settings.

Drs Saultz and David, as well as the FFM, point out the pressing need to reform health care delivery in the United States. Their recommendations for modernizing primary care services are laudable. However, the reality is that we are stuck with our current dysfunctional system and payment structure. Family physicians can offer sensible innovations, such as a greater emphasis on electronic services, or “do the right thing” with population/community-based care, but until we are reimbursed to do so, we will create even more frustration for ourselves. We can try to be proactive, but I suspect that when these services are finally covered, we will find we are vying with others whether or not we were first.

Regardless of how we deliver health care, we must do a better job of recruiting students to family medicine. Drs Saultz and David note that our applicant pool is older and less likely to opt for full-time positions when they graduate. It is unclear to me why these students, who will have fewer years for their career and who prefer a more moderate lifestyle, will be enthusiastic about a longer residency.

Drs Saultz and David cite a survey in which less than one third of residents and faculty favored a 4-year program, and yet they suggest that we increase the training period to energize our specialty. You can talk the talk of signing up for additional training, but will you walk the walk? We cannot know what effect changing the length of training will have on resident recruitment unless we offer alternatives. The limited number of students in the survey above who preferred the 4-year option, or who currently select combined residency programs, does not bode well for a 4-year program.

Drs Saultz and David do not address the economic consequences of changing the length of training. While medical educators may debate the merits of a 2-year versus a 4-year residency, I suspect our financial advisors would be united in recommending shorter training. Our current payment structure does not differentiate between experienced and more-junior clinicians. Neither Drs Saultz and David or the FFM explain how graduates of a 4-year program would be compensated better than graduates of a 3- or a 2-year program. The FFM does propose mechanisms to increase family physician salaries by 26%, but there is no guarantee that their proposals will be accepted, and if they are accepted there is no reason why the changes would not similarly benefit graduates of a 2-year program, especially since the recommendations focus on ambulatory, primary care services that should be the focus of a 2-year program. Let us also not forget that our residents right now can get their license after 1 year of training, sign up for a moonlighting position, and get paid close to what we pay our faculty. When it comes to decision time, the bottom line is the bottom line.

Drs Saultz and David express concern over stagnation in our specialty. In my opinion, a 2-year residency will create interest and excitement, while selling a 4-year program will be like cajoling our kids to take their medicine. Drs Saultz and David reference general internal medicine’s analysis of future training needs, calling for a 2-year core training period with options for specialization within a 4-year program. The Association of Program Directors in Internal Medicine have also called for “a core training of 2 or 3 years, followed by appropriate lengths of specialized training.”

Canada already has a 2-year family medicine residency with additional training opportunities.

The ultimate consequences of modifying the length of family medicine training will not be known unless, as is suggested by the FFM, we are open to innovation. To best position our specialty, we should actively support the establishment of both 2-year and 4-year residency programs. We should objectively assess these experiments by monitoring parameters including recruitment, demographics, attitudes and perceptions, additional training, board passage rates, practice settings, breadth of practice, satisfaction, and incomes. Given the uncertain direction of health care delivery in our country, I believe there are compelling arguments in favor of a more nimble, flexible, and adaptable 2-year family medicine residency.

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