The Imperative for Residency Innovation

W. Perry Dickinson, MD

(Fam Med 2011;43(4):283-5.)

As a part of the recent Working Party meeting of the leaders of the national family medicine organizations, there was a daylong session with members of the Family Medicine Review Committee and other guests to discuss the possibility of extending family medicine residency training to 4 years. A consensus regarding such a change did not emerge from the Length of Training Summit, but what did come through clearly was the strong need for residency programs in family medicine and the other primary care disciplines to go through a period of innovation and improvement to better prepare the primary care work force of the future. This column will not focus on the pros and cons of extending residency training but rather the imperative for innovation in primary care residency training.

What’s the Problem?
Regardless of the exact model for primary care in the future, it is clear that a strengthened system of primary care has to be at the center of a remodeled US health care system to provide higher quality, more personalized health care at a lower cost. It is also unfortunately clear that the current performance of our primary care practices is not optimal for taking such a central role. Quality has not been emphasized in our current system, with payment systems instead incentivizing quantity and procedures. Primary care practices and residencies have been slow to incorporate new technologies, processes, and innovations that have been shown to improve care and would provide the basis for a stronger primary care base. Disturbingly, we have seen gradual erosion in the central pillars of primary care upon which the value of primary care is based, including comprehensiveness and continuity of care, convenient and available first access to care, and coordination of care. This erosion is clearly multi-factorial, with our dysfunctional payment system a huge problem, but the fact remains that our current primary care system is not well positioned to successfully take on the sort of central role in a restructured health care system that we would like and that the United States badly needs.

There are disturbing trends in our residency programs that further raise concerns. Performance by residency graduates on the American Board of Family Medicine certification exam has been steadily declining. Increasing numbers of residency programs are being cited for the poor performance of their graduates on the exam. Residency program directors would suggest that this is a problem with the students who are entering our programs. Residency educators from all fields have increasingly complained that students graduating from our medical schools do not have the necessary clinical training and skills, and some responsibility does rest with medical schools that have focused too much on the basic sciences and not enough on clinical training and exposure to patients. Recruitment of students into primary care residency programs also has been difficult for multiple reasons, including the economic pressures of increasing debt load in the face of decreasing primary care reimbursement relative to that of other specialties. However, while some of the blame may rest with the diminished overall quality of residents entering primary care programs, that is only part of the problem.
Residents are emerging from our programs poorly prepared for the realities of practice, especially for the enhanced new models of practice such as the Patient-centered Medical Home (PCMH) that are being promoted as part of health care reform. Residents need to emerge from our programs well trained in the new models of practice and the quality improvement and change management processes necessary to move our practices forward, but that is only occurring sporadically. A threat to the comprehensiveness of primary care is the contracting scope of practice seen among primary care clinicians. Data would indicate that some of this contraction is due to a lack of confidence in skills in key areas of practice, although clearly economic pressures play a huge role as well. Regardless, there is certainly available data to indicate that our primary care residencies are not preparing their graduates adequately, and this is concerning at this critical juncture where primary care needs to be positioned to take on a more central role in our health care system.

The Stagnation of Primary Care Residency Education
There are many reasons for the apparent decline of primary care residency education that fall outside of the control of the residency programs themselves, including the payment system and the lack of clinical exposure and skills of medical school graduates as mentioned above. Family medicine educators often complain bitterly about the extremely detailed and restrictive nature of the Program Requirements for Graduate Medical Education in Family Medicine that basically dictate the form of residency education. Those requirements have historically relied on “counting” methodologies to document the quality of residency programs, detailing specified numbers of months or hours of training in a daunting list of areas. In particular, the amount of time required in the hospital or on specialty rotations greatly restricts the time available for the more longitudinal aspects of ambulatory primary care practice, including time spent seeing continuity patients in the practice but also learning such critical topics as quality improvement, practice management, and the nonvisit aspects of new models of primary care. Residency faculty members complain of being locked in by the program requirements, unable to innovate due to their incredible detail and lack of flexibility. The tight financial status of most residencies further restricts the time and resources needed for innovation. And now there are the additional problems presented by the new resident duty hour restrictions, which will further decrease the time available for resident training and increase the burden on our already taxed faculty members. There is a good deal of justification for saying “woe is us!” However, that is absolutely not an appropriate response.

New Hope and Opportunities
I believe that there is reason for optimism for residency programs at this juncture. While the promise of primary care payment reform has not yet materialized to a great extent, there are indications that this will emerge over time. The re-energizing and enhancement of primary care remains a hot topic among policy makers, and there continues to be slow movement in that direction. Payment reforms that would incentivize and enable many of the changes needed by our primary care practices and training programs are still quite possible, even in the face of governmental budget deficits and the backlash against the Accountable Care Act.

Even more promising is the likelihood that the current process of revising the family medicine program requirements will provide more flexibility, in ways that residency faculty have been requesting for many years. At the Length of Training Summit, Review Committee representatives gave an overview of the tentative, not yet finalized revisions that will emerge over the coming months, to take effect in July 2013. My notes from that overview indicate the following highlights, all of which are relevant for this discussion:

1) The length of the requirements document has been cut almost in half.
2) There will be more latitude for and emphasis on longitudinal curricula.
3) There will be fewer counting requirements and more of a focus on documenting the competency of residents in the various areas.
4) Elements of the PCMH model are included throughout.
5) Consistent with #4, there is an emphasis on producing a high-quality personal physician for the PCMH.
6) Program and practice ties to community resources will have increased emphasis.
7) Improved integration of mental and behavioral health will be stressed.
8) Residents will need to be well trained in quality improvement.
9) Professionalism will be another area of emphasis.
While the final details of the revision are still forthcoming, I believe that it is clear that the Review Committee has been listening closely to the comments and suggestions of the family of family medicine organizations, and this revision could represent one of the most critical and major shifts in family medicine residency training in many years. The revision should provide more flexibility for our residency programs to do what they think is necessary to improve the training of their residents, at the cost of now having to better measure and document the competency of their graduates instead of relying on documentation of the number of procedures and hours of training.

The Imperative for Innovation
These possible changes in the family medicine residency program requirements are extremely propitious, coming at this time of a potential enhanced role of primary care in the health care system with exciting new models of care emerging, and this could and should lead to a period of innovation in the family medicine residency training programs across the country. The Preparing the Personal Physician for Practice (P4) project and other residency program and practice redesign efforts provide some guidance to programs looking to innovate and improve. A preliminary report from the P4 evaluation team at the Length of Training Summit would suggest that innovations such as individualizing portions of training based on resident future practice plans, increasing the length of training to allow focused training in key areas, implementation of the PCMH in the residency practice and curriculum, moving training out into community practices, and many others can be both successful and attractive to student applicants, who appear to particularly value innovation. There is an increasing buzz of excitement around primary care among medical students that has not existed in years, and they are attracted to programs that are innovative and moving toward a new model of practice. It is vital that our family medicine and other primary care residency programs innovate and improve to train the necessary workforce for an expanded and enhanced role for primary care, and now is the time to do so.

With this imperative for innovation comes a necessity for scholarship, since without careful evaluation, we have no way to be sure that the changes that we have made have resulted in improvements. And, if the results of the evaluation are not reported in our meetings and journals, other programs will not be able to duplicate the successes and avoid the failures. Historically, we have done a poor job of evaluating our educational innovations, and we cannot afford to continue that pattern. We need to develop into a learning community of residency programs and faculty, striving to provide better education to our residents and to produce the best possible personal physicians for the health care system.

Arising from this innovation imperative are many important needs for faculty development. Most of our faculty members are not expert in quality improvement, aspects of the PCMH, educational program development and evaluation, competency development and measurement, and other necessary skills. STFM and the other family medicine organizations will be working together to provide this training over upcoming years.

I have communicated with many residency directors and faculty members about the imperative for residency innovation and specifically the need for transforming our practices to become medical homes and have heard a great litany of reasons why they can’t change. I hear a similar list of reasons when I talk with primary care physicians out in practice as to why they don’t have the time or resources to change. I also have seen some of our most poorly resourced programs and practices do remarkable transformations in their training and patient care, proceeding with a can-do attitude rather than being stopped by all the barriers and problems. These days, I just nod my head to all of the reasons why people can’t change, say that is true, and then ask how they are going to do it anyway. Now is the time for all primary care residency programs to consider how they can innovate to become better—or to stand off to the side and risk becoming irrelevant. As Will Rogers said, “Even if you think you are on the right track, you’ll get run over if you just sit there.” This will require some risk taking and strong leadership, but I am convinced that our programs and faculty have the right stuff to do what needs to be done.

CORRESPONDENCE: Address correspondence to Dr Dickinson, University of Colorado, Department of Family Medicine, Mail Stop F496, 12361 E. 17th Avenue, Room 3225, Aurora, CO 80045. 303-724-9754. Fax: 303-724-9747. perry.dickinson@ucdenver.edu.