Make Room for Teaching in the Patient-centered Medical Home

Anthony Cheng; Mark Loafman, MD, MPH

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As an organizer for the American Medical Student Association, I work with a national network of students passionate about health care justice, unafraid to engage in contentious battles and ready to answer the call to primary care. I appreciate the data about primary care physicians’ positive impact on the health of nations, believe that primary care is a matter of social justice, and appreciate the pivotal role primary care physicians have in caring for the underserved. I have worked alongside grassroots campaigns in support of legislation advancing primary care and have joined millions of Americans to celebrate the passage of the Patient Protection and Affordable Care Act of 2010, and I am elated that primary care has finally become common ground for national health reform.

My enthusiasm for primary care is diminished, however, by the sacrifices in salary and prestige that often accompany a career in primary care. Also concerning is the possibility that the breadth of primary care medicine is too much to master, that we will become the proverbial “Jack of all trades, master of none.” Worst of all, I fear that I will be an ineffective health care provider, a perception reinforced by my early clinical experiences. Facing a panel of patients that are chronically hyperglycemic, hypertensive, overweight, or who can’t stop smoking made me feel that primary care’s 15-minute visit model is wholly insufficient for chronic disease management.

My medical school excels at training specialists, and I have acutely experienced the reverberation of these fears within the echo chamber of the collective medical student psyche. I can attest that these fears are powerful. Though perhaps irrational, it would be unwise to regard these fears as unfounded. Primary care has its issues, and blaming non-adherent patients and a fragmented, poorly prioritized health system for shortfalls in health outcomes does little to enhance primary care’s image.

My family medicine mentor appreciates the student’s perspective. For years, he has watched idealism, and the initial appreciation for family medicine that often comes with it, peak early and then decay as students see how hard it has been for us to achieve the vision for doctoring we so passionately, and at times defensively, proclaim. He loves being a family doctor and appreciates that a well-trained and empathic family doctor applying the healer’s art can often be amazingly effective. He has seen the occasional student experience family medicine as the ideal career and decide that nothing else makes sense. However, the majority of students are less willing to trust their instincts and quickly come to the conclusion that a doctor working alone with a patient for 15 minutes armed with little more than a prescription pad does not have good odds against the myriad of problems encountered in the primary care office.

Reflecting on each year’s national Match results, he has sometimes thought poorly of students who had insight into the need for primary care but were unwilling to make the difficult, “right” choice. He now believes that the problem with primary care is not that students are self-interested but rather that primary care has been underpowered at the system level. Thankfully, a systems-based solution in the form of the Patient-centered Medical Home (PCMH) is rapidly emerging across several levels of health care. Honest and transparent conversations with idealistic young learners about why family medicine is awesome, why it has been so hard and under-appreciated, and now, finally why we are hopeful that primary care will be better equipped to address the challenges of chronic disease. Such an exciting project is likely to make mentoring much less of an uphill battle in the future.

As a student, this type of mentorship coupled with involvement in a practice organized according to the principles of the PCMH rekindled my interest in primary care. I had the opportunity to participate in a quality improvement project and witnessed how the challenges of primary care could be transformed.

From the Feinberg School of Medicine, Northwestern University.
into opportunities for innovation. At a Federally Qualified Community Health Center, physicians caring for patients with diabetes often had difficulty motivating patients to make behavioral changes. To address this, the clinic invited community members into the care team and trained them to provide diabetes education and self-management support through education and goal setting. It was hoped that these lay diabetes educators could bridge cultural and language barriers, strengthen therapeutic relationships, and help patients take better care of themselves.

We used information technology to study the types of goals set (diet, exercise, or medication related) and whether they were achieved. We then drew attention to the importance of improving self-efficacy and were able to suggest what goals would likely have the highest rate of attainment. This helped me realize that the medical record can be used to guide practices in real time and provide feedback on quality measures with a reasonable financial cost. We have high hopes that we will continue to make strides toward providing high-quality health care to our economically disadvantaged population. Holding on to hopes such as these has been hugely satisfying—I began to see health inequality not as an immutable fact of socioeconomic disparities but as a problem that I could help to solve on a community level by helping to build a medical home, even as a medical student.3

Presenting our conclusions during interdisciplinary rounds helped me realize that tomorrow’s primary care physician is not a lonely doc, trudging from patient to patient with little help but rather the leader of an inter-professional team. The synergy of physicians, nurses, pharmacists, quality improvement staff, and lay people all working together is inspiring. Observing how different members of the care team interact and draw upon the expertise of their colleagues helped me realize the physician as leader need not master every aspect of patient care to be a great doctor. The great doctors I observed did not know everything about medicine, but they did have a command of their clinical domain, good relationships with their patients, and skill calling upon the expertise of colleagues when needed. I realized that choosing to pursue primary care is not dooming myself to being a mere maverick but rather positioning myself to be the leader of an interprofessional, patient-centered team focused on health outcomes. With increasingly effective patient-centered care, we hope that patients will come to see their primary care physician’s office as a true medical home, utilizing specialists for increasingly well-defined problems and leaving more of their care in the hands of their medical home team.

This work also helped me appreciate the tremendous amount of knowledge yet to be gained about how to effectively implement the therapies and lifestyle changes known to have the greatest impact on the lives of patients with chronic disease. Until we are better able to promote behavior change, our patients will remain unable to take full advantage of scientific progress. Thus, primary care research to coordinate care, improve patient compliance, and support individual behavior change has the potential to greatly multiply the power of existing medical interventions. This idea has captured the interest of leaders across the country, leading to investment in institutions including the UCSF Center for Primary Care Excellence, the Dartmouth Center for Health Care Delivery Science, and the Harvard Center for Primary Care.

We believe that this idea is not adequately conveyed in undergraduate medical education where primary care is framed by the standard clinic visit and the same old losing battle to increase the primary care workforce. Witnessing wonderful doctor-patient interactions while shadowing primary care physicians and learning about the role of primary care in solving health disparities piqued my interest in primary care. But it was only after seeing the spirit of continuous quality improvement and interdisciplinary care embodied by the PCMH model that I came to see primary care as a force beyond the opportunity to have rewarding relationships with patients. Undergraduate medical education effectively inculcates the value of evidence-based pharmacologic treatment decisions into a student’s professional values, so it is easy for a student to see the value of applying empiricism to systems of health care delivery. We believe that raising a student’s awareness of the wealth of unanswered questions about how to strengthen health care delivery and of the tools of the PCMH to solve them can make a career in primary care imminently compelling.

The junior medical student’s fear of non-expert status and therapeutic impotence in a primary care career may seem exaggerated to the seasoned clinician, but they are grounded in truths. Physicians do struggle to support behavior change while coordinating care for a variety of complex conditions, and it is a challenge to master the breadth of knowledge within general medicine while also ministering to the psychosocial dimensions of a patient’s experience. These demands make it difficult to achieve objective improvements in health outcomes, and this challenge is obvious to students. We believe that experience with the PCMH can allay a student’s fears. If we are to attract today’s students into primary care, we need to portray primary care in its entirety. The standard clinic visit is losing its primacy in
the future of primary care, so we need to invite students into the challenges and excitement of reinventing primary care through the PCMH.

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CORRESPONDING AUTHOR: Address correspondence to Mr. Cheng, 900 North Lake Shore Drive, Apt. 2705, Chicago, IL 60611. a-cheng@fsm.northwestern.edu

References
