In my first President’s Column,1 I asserted that STFM should spread the Patient-centered Medical Home (PCMH) model to every one of our medical school faculty, residency program, and community preceptor teaching practices. I have proposed to the Board of Directors that STFM join the Patient-centered Primary Care Collaborative (PCPCC)2 to advocate for this model of care. I also think that we should consider partnering with the Institute for Family-centered Care3 and the New Health Partnerships4 to advocate for patient- and family-centered care.

The question has been raised whether attention to these linkages around patient care distacts STFM from its primary mission of education. On the one hand, I hold out Jim Collins’ work that visionary organizations are those that preserve core values and purpose;5 while on the other hand I promote efforts that focus on the model for our clinical practice. Am I being inconsistent? Does an agenda dealing with the model of care in our teaching practices fit with the core values and purpose of STFM?

I offer the following regarding our mission statement and our primary responsibility for the Future of Family Medicine strategic priorities in support of why I think this focus is consistent with our primary mission as a society of teachers.

(1) STFM mission statement. Our current statement says that STFM is “dedicated to improving the health care of all people through education, research, patient care, and advocacy.” Our previous mission statement said that we were “dedicated to enhancing family medicine education by developing and supporting a community of educators, scholars, and clinicians.” For some time, I have thought that our previous mission statement was a better reflection of what STFM stood for. If this was still our mission statement, then joining the PCPCC would not be a priority for us. I do believe, however, that focusing on the structure and function of our teaching practices would be relevant to enhancing family medicine education, and I will come back to this point later. Given STFM’s current mission statement, I believe that being involved in improving patient care by joining the PCPCC and partnering with other organizations that advocate for patient- and family-centered care is appropriate. Which mission statement expresses best the views of our members and leaders? The Strategic Planning Committee is leading a process to reassess our mission statement that will guide the direction of this part of the discussion.

(2) Future of Family Medicine strategic priority. STFM is charged with taking the lead on strategies for recruiting and training a family physician workforce that will meet the needs of the US population.6 The Future of Family Medicine report promotes the personal or patient-centered medical home as the preferred model for meeting population needs and as the first priority for health system reform.5 Recruiting—STFM has started FutureFamilyDocs.org and regular stories in The STFM Messenger about efforts to recruit premedical students into medicine who are likely to share the values we hold in family medicine. The literature supports this strategy. The literature also indicates that a required third-year family medicine clinical experience is directly related to the rate of recruitment of students into family medicine.7 Our anecdotal experience at Baylor College of Medicine is that students who had not seriously considered family medicine were surprised by how much they enjoyed the clinical experience in the office of a community volunteer faculty member. We have had students switch their choice to family medicine based on their clerkship experience. It was not the classroom teaching but the experience in the clinical setting that made the difference. I suspect that other departments have had similar situations with students. This is consistent with the hope for developing the New Model of Family Medicine in that the change in the clinical model of care in family medicine would end the hamster treadmill feeling of practice and create a more-positive practice model that would be attractive to students. This strategy depends entirely on whether our teaching practices for students are New Model practices or PCMHs. Since students rotate in medical school faculty practices, residency program practices, and community volunteer faculty practices, we need to work to have all of these teaching practices become PCMHs.

Training—Given that the Future of Family Medicine promotes the personal or PCMH as the priority for
health system reform, our responsibility as teachers is to prepare our students and residents for that practice model. We need to articulate the competencies necessary for functioning well in a PCMH and to develop curricula for providing learners with the knowledge base required for that environment. The Competency-based Curriculum Workgroup of the FFM Special Task Force is developing modules on advanced access, informatics, performance improvement, evidence-based medicine, group visits, and the chronic care model. The Competency-based Curriculum for Group Visits has been released on www.fmdrl.org. Members of the Society also have posted their experiences with teaching aspects of the medical home or New Model that can be accessed using those search terms at www.fmdrl.org.

The FFM Group Visit Competency-based Curriculum is described as “a dynamic longitudinal way of teaching, whereby the student learns by actively planning, conducting, and debriefing about each visit with team members.” This approach to education fits with the educational philosophy that students learn what they do.8 The importance of the clinical experience is supported by the experiential learning cycle of abstract conceptualization, active experimentation, concrete experience, and reflective observation.9 Abstract conceptualization and reflective observation, which are typical classroom instruction activities, are important but are incomplete without concrete experience and active experimentation in clinical settings. Students and residents continually remind us how the clinical experience compares with classroom didactic instruction. If we teach about medical home topics in class settings, our messages will not stick unless our learners see the concepts in action in clinical sites. We need to pay particular attention to having teaching practices with medical home features, or we risk marginalizing the PCMH initiative and losing credibility.

Our clinical practices are our most influential teaching venues, and the messages embedded in the clinical sites can reinforce our teaching in traditional didactic settings or can subvert and negate formal or intended lessons. The clinical site is part of the “hidden” or unintentional curriculum whose power is well recognized.10 The unintentional curriculum is not truly “hidden” and can be modified to be consistent with the intended curriculum. Achieving this requires attention to both didactic instruction and clinical sites and underscores the critical nature of the curriculum that surrounds the clinical site experience. Being in a medical home practice itself may be a powerful message but may not be sufficient. The concrete experience that will likely be most effective is preceded by abstract conceptualization to prepare students and residents for the experience and followed by reflective observation to put the experience in context. We need both effective didactic curricula on features of the PCMH and exemplary PCMH practices for learner clinical experiences.

I believe that putting learners in teaching practices that are PCMHs is a primary responsibility of our educators. This implies that we help transform/remodel those practices, including medical school faculty practices, residency practices, and community volunteer faculty practices. We can work toward this without being part of the PCPCC, but our impact may be less if we do not join with the PCPCC or other organizations advocating for PCMH models. I am suggesting a rather ambitious agenda. There are more than 100 medical school practices and more than 450 residency program practices that would need to become PCMH teaching practices. In addition, if you estimate that each medical school has a minimum of 30–50 community practices in which they place students, then we are talking about roughly 3,000 to 5,000 community teaching practices we would want to remodel into PCMHs. The PCPCC and other similar groups may be able to help us transform those practices.

In summary, I believe that one of our primary concerns as teachers of family medicine must be the types of clinical practices where we place our learners. The models of patient care that students and residents experience in our clinical settings exemplify Marshall McLuhan’s adage “The medium is the message.”8 Rather than distracting us from education, how we practice patient care is the message of our education. Let’s model the message we intend to deliver, namely patient-centered care. Patient care is core to STFM’s mission and to our mission as educators.

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REFERENCES

2. Patient-centered Primary Care Collaborative. www.patientcenteredprimarycare.org/about.htm.