

Breaking from Tradition: Refocusing the Locus of Family Medicine Training—Reaction to the Paper by Perry A. Pugno, MD, MPH

Marguerite Duane, MD

It is a privilege to respond to the proposed model for the future of family medicine education as put forth by Dr. Perry Pugno.¹ Many of the ideas he shares are similar to my own, but I also respectfully disagree with others. The current model of family medicine training was developed more than 40 years ago, and there have been limited large-scale changes in training since then despite the multitude of changes in medicine, the health care system, and our society as a whole.² Nonetheless, the seeds have been planted, beginning with the Future of Family Medicine project and now the Preparing the Personal Physician for Practice (P4) project.^{3,4} Both of these call for transformational change to better meet the needs of our patients by preparing future family physicians to practice within new models of care.

Dr. Pugno¹ proposes 3 key elements that must be incorporated into the new model of family medicine education:

1. a 4-year training period;
2. a longitudinal educational experience in continuity of care with a patient population based in a community practice setting; and
3. the capacity for trainees to customize their residency experience by selecting a value-added component to enhance their training.

Although my foray into family medicine residency training research focused on the 4-year training model, I do not believe that successful completion of training should be determined by a specific time limit. Rather, it should be based on an

individual resident's successful completion of the core competencies we expect all family physicians to master. A resident's previous education, experience, and motivation to learn may influence how long it will take him or her to master the core competencies. Once completed, residents should receive their certificates and be rewarded with the additional responsibility and salary accorded to junior faculty members if they choose to remain for the remainder of their fourth year.

I wholeheartedly agree with Dr. Pugno's second premise that resident physicians must "be trained in an environment that emphasizes the care of a continuity patient population."¹ The current structure of rotation or block training is centered on the hospital and residency rather than on the patient or resident. If we expect future family physicians to practice in a patient-centered manner, their training program must reflect this model. Rather than assigning residents to cover services to insure the staffing needs of the program or hospital are met, there should be more flexibility to allow residents to "follow" their patients as they move through the health care system. Ideally, a small team of residents would be the primary care physicians for a core group of families. Whenever a family member interacts with the health care system, one of the resident team members could be a part of the encounter to learn from it and create a more patient-centered experience by being there to provide support to the patient. For example, if the resident refers a patient for a colonoscopy, the resident should be present and should participate in the procedure. Or, if a patient with diabetes is referred for nutrition counseling, the resident should join in the session to learn more about appropriate dietary recommendations so they are able to reinforce them during future visits. Because the learning needs of the individual resident team members may vary and there may be scheduling limitations, it is important to approach this as a team effort to ensure that the needs of the residents and patients

From the Family Medicine Department, Georgetown University, Washington, DC.

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Corresponding author: Marguerite Duane, MD, Spanish Catholic Center of Catholic Charities, 1618 Monroe Street NW, Washington, DC 20010 (E-mail: mduanemd@yahoo.com).

may be met while also providing true continuity of care as the patient navigates the health care system.

The opportunity to customize the educational experience through areas of concentration is the third key element of Dr. Pugno's proposal.¹ In an age in which pursuing a "specialty" is all the rage, we must be clear that the purpose is not to create more "partialists." Rather, the purpose is to allow residents to explore areas of personal interest while encouraging them to advance their knowledge and skills in areas that will better prepare them to provide more comprehensive care in their future practice settings. For example, residents considering a career overseas may be encouraged to pursue advanced procedural skills and emergency stabilization training even if surgery or the emergency room were their least favorite rotations during medical school. Residents considering a career in public health may be encouraged to pursue additional training in policy or preventive medicine in addition to a personal interest in medicine relating to the human immunodeficiency virus. Although the opportunity to pursue a scholarly project should be made available to all, it should not be a requirement because many family physicians will be competent to provide excellent evidence-based primary care to a community of patients without these additional lines on their resume.

Dr. Pugno's proposed 4-year curriculum¹ contains all the key elements that I believe should be part of the training program, but the breakdown seems eerily similar to the current structure. I would argue that the order of educational experiences should be different and definitely longitudinal in nature. After 2 years of primarily inpatient clinical experience during medical school, residents should spend the majority of their first year in the

outpatient setting, where they will be immersed in the philosophy of family medicine with a focus on continuity of care in the community setting, chronic disease management and the care model, preventive medicine and public health, and quality improvement. With this broad framework providing a strong foundation, residents will be better prepared to handle the demands in the inpatient and emergency department settings and to critically evaluate the care provided to their patients in subspecialty offices during their second and third years. As residents near completion of their third year, the need for more training in the core competencies should be clear and/or the decision to pursue additional training in areas of interest or need can be made. Ideally, residents will have developed the "intellectual honesty" to know what they know and what they do not know, and to know where they can acquire the knowledge or skills that they need to provide high-quality, patient-centered care to their community.

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