COMMENTARY

Family Physicians Closing Their Doors To Children: Considering the Implications

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Together, general pediatricians and family physicians comprise the core workforce that delivers primary care to children in the United States. Although the supply of general pediatricians has grown dramatically relative to the population of children in the United States in recent decades, the geographic locations of pediatricians remains decidedly maldistributed relative to children in the United States. Family physicians, in contrast, are more equitably distributed relative to the population, and this workforce remains critical for ensuring access to primary care for children.

Yet, as reported in this issue of the *Journal*, Bazemore and colleagues[1] demonstrate that, over the past decade, increasingly few family physicians provided any care to children in their practices; as of 2009, only 68% provided any care to this segment of the population, a 10% absolute decrease since 2000. This work complements previous research from Freed et al[2] that demonstrated that the role of the family physician in providing ambulatory services to children diminished significantly over the period from 1990 to 2000. Together, these studies demonstrate a persistent and potentially alarming trend.

The brief report is descriptive only and displays trends only at a national level. It does not address regional or practice variations in the likelihood of a family physician delivering services to children, which is critical to understanding the impact of these trends on the care of children. For example, one partner in a sizable single specialty practice or a large multispecialty group who discontinues care of children, perhaps in the later years of practice by natural attrition, has different implications when compared with a rural doctor who is the only local provider of primary care services who decides not to care for children.

The reasons for the declining role of family physicians in the care of children have not been studied adequately. It may be that the growing supply of pediatricians has created overt competition that has left family physicians wanting for children in their practices. This may be exacerbated by the vanishing rates of obstetric care in family medicine, arguably the most natural source of pediatric patients for the family physician. It may be that the growing demands of the baby boomer population, coupled with a dearth of general internists, has crowded out children from family physicians' care. Perhaps the problem lies in low Medicaid reimbursement for children's services, or maybe residency training leaves new family physicians uncertain about their ability to meet the diverse primary care needs of children, who increasingly suffer from chronic illnesses and behavioral/developmental challenges. The confluence of these or other factors may leave family physicians with little choice but to close their practices to the children in their communities. Whatever the sources, the consequences of this restricted scope of practice could be pronounced, particularly if its prevalence continues to grow.

The potential implications for children in rural and underserved communities are obvious, given the reality that family physicians are often the only provider of services in these communities. When

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such providers exclude children, it could have particularly perilous effects on their access to care and their receipt of preventive services.

Beyond enhancing geographic access to care, family physicians have a distinct contextual perspective on the health of the child. The family physician is uniquely able to consider the interrelationships between parental health and the health and well-being of the child. Furthermore, they are able to serve the parent's health needs in ways that can directly improve the health and well-being of the child. One need look no further than management of maternal depression or parental smoking cessation for common examples of situations in which a family physician can bring decisive value to the health and well-being of the child. As fewer of these physicians provide any care to children, fewer children can benefit from this distinct asset.

From a societal standpoint, an underappreciated asset brought by the family physician workforce is versatility. Family physicians can and do serve a unique role among physicians in alleviating relative deficiencies of workforce capacity within a given health care market. A family physician, equipped to manage primary care, obstetric care, and the minor procedural needs of a population from birth through hospice care, can meet local needs flexibly, providing different services in different markets and being adaptive to the local workforce and the local population. As family physicians restrict their practices, this workforce flexibility is diminished.

Among the most concerning potential impacts of these trends relates to residency training. If the reported steady decline in children's visits to family physicians and the growing proportion of family doctors who do not see children are reflected in any way in family medicine training programs and/or the community practices used by training programs, then today's family medicine residents may receive a diluted and possibly insufficient training experience in providing primary care to children. This could compromise the quality of care these physicians are prepared to deliver to children in practice or may dissuade these young physicians from providing such care at all if given the choice. Indeed, such preferences to opt out of caring for children could increasingly lead family physicians to avoid seeking practice opportunities in rural and underserved settings where such options are less likely to be available. Left unchecked, a vicious cycle could ultimately ensue, wherein family physician faculty are increasingly uncomfortable, unwilling, or unable to teach and model the delivery of primary care of children to their trainees.

Perhaps this possibility, no matter how remote, should be a call to action for pediatric educators to reach out to their family medicine colleagues (and vice versa) to ensure that trainees have adequate training in addressing the primary care needs of children. Indeed, the opportunity and need for collaboration in training and in practice have perhaps never been greater. Such collaborative efforts may potentiate access to high-quality care and gains in the health and well-being of the child population.

Even as the number of uninsured children approaches an all-time low, access to care is not a certainty. Efforts to increase the number of individuals with health insurance will be beneficial only insofar as there are providers ready and able to provide them with high-quality care. Ever fewer family physicians are offering care to children; it would be difficult to conclude that this is inconsequential. There is an acute need for research to understand the factors driving this trend as well as to measure its impact. Meanwhile, family medicine and pediatric physicians should increasingly come together to embrace a shared responsibility to ensure that all children in the United States have access to high-quality care.

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