Letters to the Editor

Karl Miller, MD
Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to **MillerKE@erlanger.org** or to my attention at *Family Medicine* Letters to the Editor Section, University of Tennessee, Chattanooga Unit, Department of Family Medicine, 1100 East Third Street, Chattanooga, TN 37402. 423-778-2957. Fax: 423-778-2959. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

A 4-year Family Medicine Residency Program

To the Editor:

John Saultz, MD, and Alan David, MD, have called for a national debate concerning whether our discipline should move toward a 4-year family medicine residency program.[1] The authors cite fundamental ways in which the field of medicine and learners' attitudes and aspirations have changed. These changes mandate consideration of transformations within family medicine residency training. After leading the way in innovation for 34 years, family medicine finds itself stalemated by declining interest from medical students, a plethora of new clinical and teaching requirements, and a workweek reduced to 80 hours.

We believe that family medicine residents and faculties have already spoken on this issue. A large percentage of family medicine residency programs currently offer one or more fellowships or advanced years of training under the tutelage of department faculty. These additional educational pursuits include geriatrics, rural family medicine, advanced obstetrics, sports medicine, emergency medicine, medical informatics, administrative medicine, academic medicine, behavioral medicine, and others. Faculty of these programs possess specialized skills for teaching learners in these areas. The programs are located in settings that provide ideal milieus for the acquisition of these skills.

Family physicians have succeeded in widely varied health care environments as a result of our broad-based education that prepares us to meet the perceived needs of the communities in which we practice. The skills we utilize are those we acquire practicing in the communities and are those that best fill gaps in the local health system. However, there is evidence that these perceived needs and preferences for delivery of care are changing. The family physician is similar to a pluripotent stem cell in the body that, when appropriately stimulated, adapts and develops into a new cell or different cell type. This versatility to adapt in response to a changing environment has resulted in the success of fellowships and our graduates within their respective communities.

By integrating the educational experience of the fellowships into a 4-year curriculum, we are offering medical students more than merely additional time in the same curriculum. The Future of Family Medicine Project opened the door for refinements in the basic curriculum of family medicine and avenues for pursuit of additional interests within the 4 years of graduate education. Combining the fellowship experience with 3 years of family medicine education offers interested medical students an added educational experience without the burden and expense of relocating. While some confusion may still exist about the family physician's "role identity," programs will be differentiated by the skills taught. This will aid prospective residency applicants in choosing the program(s) most closely aligned with their personal and professional goals and will benefit medical care organizations desiring to hire our graduates. Those reengineered programs that thrive in the new environment will be in the best position to meet the medical needs of our society.

Drs Saultz and David have described reasons our changing times necessitate making this courageous move. We endorse their belief and feel that our current educational efforts are not capturing student imagination. We have little to lose by offering medical students more than just an additional year of "more of the same." As these innovative distinctions are made among our academic departments and residencies, interest should again be generated with family medicine, attracting the most creative medi-

cal students to our discipline. In turn, the practice of family medicine can better address the medical needs of our society and communities.

Gregory H. Blake, MD, MPH
M. David Stockton, MD, MPH
Department of Family Medicine
University of Tennessee-Knoxville

REFERENCE

1. Saultz JW, David AK. Is it time for a 4-year family medicine residency? Fam Med 2004;36(5):363-6.

The Length of Residency Training—Can We Be Flexible?

To the Editor:

In their commentary, Drs Saultz and David propose extending family medicine training to 4 years.[1] Recently, Duane et al surveyed a sample of family medicine residents, program directors, and practicing physicians and found significant but not definitive interest in adjusting program length and content.[2] The Future of Family Medicine analysis encouraged flexibility and innovation in family medicine training programs. Specific recommendations around program length and clinical focus were discussed briefly, but no clear direction was given.[3]

Although the rate of decline in 2004 US seniors matching to family medicine decreased, the specialty continues to not attract future physicians at the levels needed to replace those retiring or stopping clinical practice. Other primary care specialties also continue to struggle and are looking for creative solutions to their future. Recently the Society of General Internal Medicine (SGIM) has proposed increasing the flexibility of the last 2 years of general internal medicine residency training.[4]

A flexible model for family medicine training would meet the concerns addressed by Drs Saultz and David, would accommodate the various viewpoints found by Duane et al, and would follow the Future of Family Medicine's guidelines around innovation and flexibility. An additional benefit would be increased dialogue among all primary care disciplines, an interchange that is critical as family medicine seeks to navigate the future. Merging forces within primary care brings many positive opportunities.

Current family medicine educational guidelines provide some variation in training. A variety of models could be developed to expand this flexibility. One proposal would be to begin with a relatively nonflexible internship year that includes 4 months of adult medicine, 2 months of care of children, 2 months of maternal medicine and women's health, 2 months of surgery/procedures, 1 month of emergency medicine, and 1 month of behavioral and health system exposure. Both inpatient and outpatient experiences could be included in this foundational year.

During the following training periods, residents would be allowed to pick and choose from a menu of further experiences. Following completion of each menu "block," residents could apply for certification around that block. Full family medicine certification could require completion of at least two blocks. Ongoing exposure to a continuity clinic including office behavioral medicine throughout each block would be required. Each block could have 1 month of elective and 5 months of required time. Core menu blocks could come in 6-month increments and include adult medicine—inpatient, adult medicine—outpatient, care of children, maternal medicine and women's health, procedures, emergency room, and community medicine.

Full training in all seven core areas of primary care would require a 4.5-year experience. Other blocks such as geriatrics, sports medicine, preventive medicine, and public health or research could also be developed.

Allowing residents to mix and match clinical areas of focus would ensure adequate primary care training for the core primary care areas and at the same time eliminate extra training in areas that will not be used by the resident in the future. This should in turn encourage medical students having difficulty choosing a career path to recognize that a flexible family medicine training program is an efficient and enjoyable educational option.

Although a flexible model such as this may be valuable, it does not replace the need to continue to adjust other aspects of training. Attention to systems components of practice, including the IOM recommendations around: (1) patient-centered care, (2) interdisciplinary teamwork, (3) evidence-based practice, (4) quality improvement, and (5) informatics would need to continue to be applied throughout all educational aspects of any future model.[5]

Flexible training as proposed above is a significant change from the current model. Now, however, is the time to be bold.

Wayne S. Dysinger, MD, MPH
Department of Preventive Medicine
John Testerman, MD, PhD
Department of Family Medicine
Loma Linda University

REFERENCES

1. Saultz JW, David AK. Is it time for a 4-year family medicine residency? Fam Med 2004;36(5):363-6.
2. Duane M, Green LA, Dovey S, Lai S, Graham R, Fryer GE. Length and content of family practice residency training. J Am Board Fam Pract 2002;15(3):201-8.
3. The Future of Family Medicine: a collaborative project of the family medicine community. Ann Fam Med 2004;2(suppl 1):S18-S20.
4. Larson EB, Fihn SD, Kirk LM, et al. Task Force on the Domain of General Internal Medicine, Society of General Internal Medicine. The future of general internal medicine. Report and recommendations from the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine. J Gen Intern Med 2004;19(1):69-77.
5. Greiner A, Knebel E. Institute of Medicine. Committee on the Health Professions Education Summit. Health professions education: a bridge to quality. Washington, DC: National Academy Press, 2003.