"Ossification: the process of becoming set in a rigidly conventional pattern, as of behavior, habits, or beliefs."³

Those of us interested in family medicine residency education seem to be caught in a conundrum of our own making. On one hand, as David and Saultz remind us in this issue of Family Medicine,² we have a tradition of innovation. This tradition extends back to the original reports that spurred creation of our specialty in the 1960s. Both the Willard and Millis Reports called for flexible graduate training in what we now call family medicine. More recently, the Future of Family Medicine (FFM) report calls for continued innovation in residency training.

On the other hand, our family medicine residencies and their supervisory bodies are out of step with the evolving delivery of health care. They are increasingly rigid, making adaptation to change ever more difficult.

To make matters worse, we find our residencies immobilized by the "innovator’s dilemma."³ We are desperately in need of innovation in training, but only so-called “strong” programs are expected to innovate. However, these programs are likely to be the least motivated to do so. Why would programs change when they are succeeding with a current model of training? Necessity (ie, failure) is the mother of invention, and truly new inventions almost never meet the standards of the old way of doing things.

We must find ways to accelerate the pace of change in our residency training programs, in our departments, and in our field in general. Drs David and Saultz suggest a concrete plan to break the impasse: a “summit or consensus conference for the future” out of which could emerge consensus to implement experiments in residency training, to be evaluated in 5 years by another consensus conference. Such a conference and follow-up evaluation would clearly be positive steps, perhaps the beginning of a major change in our discipline. However, we must confront three other issues before we will be able to achieve real reform in family medicine residencies.

First, we should acknowledge that we are stuck in a model of ambulatory training that, although it was once a step forward, may have become as much of a liability as was the model it replaced.

In 1969, family medicine introduced the model family medicine center as a step forward from the old (and much reviled) “hospital clinic” in which most residents had theretofore obtained their ambulatory experiences. The Residency Review Committee (RRC) for Family Medicine implemented requirements for time in the practice, continuity of care, space, libraries, and dedicated clinical preceptors to provide family medicine residents an experience that more closely emulated the practices they would enter.

Much has changed in the way we deliver health care since 1969. Medical practice has become a complex business in which physicians must compete to attract and retain patients. Physicians practice in an array of business models, from solo practice to enormous staff model health maintenance organizations (HMOs). Family physicians are found in urban outpatient multispecialty practices, hospitalist groups, rural single-specialty groups providing full-spectrum care, urgent care centers, “boutique” practices for the rich, and “safety net” practices for the poor. Information management is undergoing dramatic change with implementation of electronic health records and point-of-care decision support with evidence-based guidelines. Insurance plans, both governmental (Medicare, Medicaid) and commercial (fee for service,
preferred provider organizations, HMOs), have become immensely more complex and restrictive. They will only become more so with the proliferation of pay-for-performance plans. These plans will require physicians to compete even more aggressively on the basis of both measured quality and cost of care.

Against this backdrop, residencies' model family medicine centers are now often costly, inefficient facilities in which service and quality measures do not keep up with the demands of the market. Although they were once innovations, they may now be dinosaurs. Many, if not most, require generous subsidies to operate, whether in the form of Medicare subsidies for residency training, hospital subsidies, or community/family physician largess and volunteerism. Not only does this put in question what we are modeling for our trainees, it makes us increasingly vulnerable in an age of governmental and health care budget cuts.

Second, we should recognize that, with the best of intentions, we have reversed the priorities of our residency education programs. Initially, curricular guidelines, including RRC requirements, were designed to help the residency curriculum keep up with realities of medical practice. Simply put, when family medicine residencies began in 1969, they were designed so practice realities came first, and the curriculum second, like this:

Practice → Curriculum

Now, curricular requirements drive practice design, like this:

Curriculum → Practice

This reversal of priorities means that residents' clinical experience is increasingly distant from the requirements of practice, just as were the old “hospital clinics” our model units replaced.

Third, we should recognize that we are being stymied by educational regulation. Not only are we suffering from overspecification as regulations continue to proliferate, we are sinking under the weight of dual outcomes expected during the uncomfortable transitional period between the apprentice model (“counting hours”) and the competency model (“measuring abilities”). Worse yet, regulations quickly become tacit or implicit policy, particularly in the current high-stakes evaluative setting where even “probation” from too many citations during RRC reviews can derail programs.

The academic culture we have created over the last 40 years is part of the problem. As a new academic discipline, it was essential that we place tremendous emphasis on developing educational curricula. We created faculty development fellowships. We enlisted colleagues with PhDs and EdDs to help us write, implement, and evaluate curricula. Many of our best and brightest faculty focused on developing excellent curricula rather than on improving patient outcomes. Nationally, we developed organizations (such as the Society of Teachers of Family Medicine) that focus on curricular and faculty development. This journal, Family Medicine, emphasizes educational research and innovations in teaching. The careers of many family medicine educators, including those of the authors of this editorial, have heavily emphasized such curricular and faculty development—sometimes in isolation from the changing realities of practice.

We should be proud of this commitment: it has had an influence throughout the profession of medicine, not just in our specialty. But times have changed. We believe that it is time for the discipline of family medicine, in both the academic and the practice communities, to embrace clinical excellence and innovation as its central focus. Residencies and departments of family medicine must step up to the challenge of the FFM report:

Faculty in family medicine residencies and in university departments of family medicine must shift our emphasis from tinkering with curricula to developing best clinical practice. Practices in which we train family medicine residents must compete based on quality, cost, patient service, and satisfaction. We should first provide measurably excellent health care and then challenge residents to keep up with us in doing so.

What are the next steps? To provide the flexibility necessary to meet these goals, we need to relax some of the burden and specificity of our current training regulations and outcome measures. The entire community of family medicine, including our RRC and the American Board of Family Medicine, should promote vigorous and responsible experimentation with different models of patient care used as family medicine training settings. Some practices may emphasize inpatient care, others outpatient. Some may include perinatal care, others not. Some may include just one or two residents as part of a small group of physicians, while others may train a large group of residents. Similar to Drs David and Saulz, we envision a 10-year period of experimentation and assessment. We believe that, at the current time, there is no one “model of practice” that will function in every community and that, similarly, there is no one detailed perfect template for how residencies should operate. Rather, the organizing principle should be to develop new models of care that improve patient outcomes and then incorporate residents into them.

We encourage innovation both in terms of specific components of
our “basket of services” and in the overall structure of the curriculum. Whichever way we go, our care of patients must evolve, and resident education must follow.

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