emailing your name and all your contact information to cafmadvocacy@stfm.org.

Turning from our theoretical plans to expand our advocacy efforts to specific advocacy goals, we have had some success moving forward with our Medicare primary care graduate medical education reform pilot. The concept of this reform pilot was developed in the fall of 2008 and has been a key advocacy effort of CAFM and the AAFP since then. Briefly, our proposal would direct a share of existing GME funding to specific pilot projects to test 4 different models of primary care training. Payments would be made by Medicare in a similar manner as the current GME payment process, but to the medical education entities (based on the number of residents training), rather than directly to hospitals. The bill authorizes the Secretary of HHS to test 2 sites for each of these 4 models: a community entity working with 2 or more hospitals; 2 hospitals working together to develop a primary care program; a hospital subsidiary or independent corporation working with the community to further primary care; and a medical school/university collaborating with a hospital. In addition, these entities would be allowed to grow their complement of residents by 50% for the term of the pilot (until completion of residency) without an impact on a hospital's resident cap.

In December, a bill to legislate the pilot was introduced in the House of Representatives. The bill, HR 3667, the Primary Care Workforce Access Improvement Act of 2011, was introduced by Representatives Cathy McMorris Rodgers (R-WA) and Mike Thompson (D-CA). We are now in the process of encouraging other representatives to sign on as cosponsors. This will be a first test of our CAN members as well—asking that they respond to our GME alert. For more information about the bill, including talking points, FAQ's, etc, as well as how to respond to the alert, please go to http://www.stfm.org/advocacy/index.cfm.

As the current session of Congress moves forward, there is another key arena that we will need committed advocacy support. Discretionary health spending is under the eye of appropriators for cuts. As part of the Budget Control Act of 2011, approximately 1.2 trillion dollars in cuts must be made or an automatic reduction of funding, called a sequester, will occur. At risk are all health programs we care about, including Title VII, primary care training, funding for the Agency for Healthcare Research and Quality (AHRQ), as well as cuts to entitlement funding, such as Medicare GME payments.

We look to all of the family of family medicine—members of the CAFM organizations and AAFP—to help us in our advocacy efforts in the coming year and beyond. If advocacy has not yet been an arena you have entered, please consider making it a priority for your development as a faculty member. We need everyone to be involved as we struggle to build and sustain the infrastructure of family medicine education and scholarship.

Should you have any questions please feel free to contact us at cafmadvocacy@stfm.org.

Mary N. Hall, MD, Academic Family Medicine Advocacy Committee; Hope Wittenberg, MA, Government Relations

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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PRODUCING FAMILY PHYSICIANS: OUR MEDICAL SCHOOLS MUST DO A BETTER JOB

The low number of US medical students choosing careers in family medicine is no longer a concern limited to our discipline. National groups including MedPac, the Commonwealth Fund, Kaiser Family Foundation, the Patient-Centered Primary Care Collaborative (PCPCC), and others have also expressed serious concern. Despite a recent slight uptick in student interest, we are far below our peak and the longer-term trend is down. For the 10-year period 2001 to 2010 an average of 1,430 students per year entered FM training (average per school 11.35, 9.1%), but for the most recent 3 years of that period, 2008 to 2010, it was down to an average of 1,317 per year (average per school 10.5, 8.1%.)[1]; osteopathic schools are also experiencing a decline.[2] And it was never enough. About 30% of practicing physicians in the United States are in primary care, while in most developed countries with a well-functioning health system it is closer to 50%. We will not get to 50% by producing less than 20% per year.

While some have suggested that the income gap between primary care and subspecialty physicians may be the largest single cause of this phenomenon,[3] it is still one among many, and it is one over which medical school educators have little control. It also does not explain the variation between schools in producing family doctors. The areas in which faculty can most effectively work for change are who is admitted to medical school and the experience that students have while in school.

The AAFP annually recognizes the medical schools that graduate the highest percentage of students

choosing family medicine. These schools, which are often community-based and have specific primary care missions, are also, often, smaller. Their high percentages do not translate into large numbers of family physicians entering the workforce. On the other hand, a number of public (eg, Indiana, Illinois) and private (eg, Medical College of Wisconsin, Drexel, Jefferson) schools that have large class sizes rank near the top in total number of students entering family medicine despite being in the second or third quintile for percentage entering family medicine.

Characteristics such as region, ownership (public/private), size, and mission explain much of the variation, but within any identifiable cohort of medical schools there are some that are doing better at producing family physicians than others. The 2 schools that consistently rank at or near the top in both percent and number of students entering family medicine, the University of Minnesota and the University of Kansas, perform much better than similar Midwestern public schools. The third-best school in combined number and percent over 10 years, Loma Linda, is a private school. Contributors to these differences include the admissions process (who is on the admissions committee and what qualifications they value), the curriculum (both formal and "hidden"), the presence and prominence of members of the family medicine faculty and clerkship, and the degree to which the institutional leaders identify producing primary care physicians as a core part of the school's mission.

Family medicine departments should be judged on a number of characteristics, including the research being done by their faculty, their leadership in implementing new models of practice, and their involvement in improving the health of their communities. The number and percent of students entering family medicine are not solely in the control of the family medicine department. Admissions is key and so is the environment in the medical school. Students who are not receptive to family medicine when admitted will not go into family medicine.[4] Students who are receptive might go into family medicine if they have a supportive medical school experience. In terms of increasing the number of family doctors to care for the American people, it is obviously graduation of students entering family medicine that matters. Our medical schools must do better. We cannot rest on our departmental achievements in other areas and ignore our failure in this critical arena.

And it has to be all schools. It is no longer acceptable to say "primary care is not our mission." We must applaud the success of the schools at the top of the percent ranking, but must also recognize that unless larger schools increase their percent, we will never achieve our national goals for production of family physicians. All of our schools need to do better. Our family medicine departments have to take the lead in helping to admit and retain the right people. At least if we care about meeting the health care needs of the American people.

Joshua Freeman, MD
Martha McGrew, MD
This commentary was written on behalf of the ADFM Education Transformation Committee

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CORRECTION

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