Family Medicine Updates

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

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THOUGHTS AND THEMES FROM THE 2016 ADFM WINTER MEETING

Are we Luddites? How can we "recalibrate"? What is a more pressing need in our Departments than producing outstanding family doctors? How can we bring joy back to clinical practice? These questions are a few among many that stimulated our thinking during ADFM's 2016 Annual Winter meeting.

A provocative plenary delivered by Steven Wartman, MD, PhD, CEO, and President of the Association of Academic Health Centers, prompted us to consider how much our adherence to the past may be our biggest hindrance to being relevant to the present and future.[1] Dr. Wartman noted that with companies and entrepreneurs producing health care solutions which go beyond and/or bypass the medical profession, our "guild" is rapidly eroding. Using a clip from the clever video "Humans Need Not Apply,"[2] featuring 2 horses discussing how the automobile would never supersede horse-drawn means of transportation, Dr. Wartman left us wondering whether we, like these horses, are Luddites—those who resist changes in technology—in our practices and Departments.

Dr. Wartman presented us with a challenge—how can generalists recalibrate for 21st Century medicine? —and an assertion—Academic Health Centers are the only institutions with the unique ability to align academics with patient care to achieve the "virtuous cycle" of education, research, and improved care and outcomes for our patients. Larry Green, MD, the Epperson Zorn Chair for Innovation in Family Medicine and Primary Care at the University of Colorado, furthered the dialogue initiated by Dr. Wartman with a focus on defining the promise of the personal physician.[3] He challenged the group by asking whether producing outstanding personal physicians is a priority for our Departments of Family Medicine and, if not, what is more important?

How departments can help in the move from volume- to value-based care within our states was a highly energizing session moderated by Duke Department of Community and Family Medicine Chair J. Lloyd Michener, MD, with 2 outstanding young leaders in our discipline, Lauren Hughes, MD, MPH and Kate Neuhausen, MD, MPH, speaking from their experiences as contributors to health policy in Pennsylvania and Virginia, respectively.[4] What we do locally and regionally is becoming more important as Departments of Family Medicine seek to exert influence in the current world of fast-paced changes in care delivery. Therefore, we set aside time for informal discussions among those from the same state or region for the first time. After the meeting, Dr. Neuhausen shared resources to help Family Medicine Departments implement 3 major recommendations that are priorities in most states: integrating addiction treatment including medication-assisted treatment (suboxone/buprenorphine and counseling) for opioid addiction into family medicine residency clinics and curricula; promoting integrated behavioral health and primary care by training family doctors to work with behavioral health providers and testing new payment models; and addressing the needs of high-cost populations by training family doctors to work in interprofessional teams to address the complex needs of "super-utilizers" and testing new payment models.

As part of a larger focus on resilience in Departments of Family Medicine, which included a panel of chairs sharing best practices from their own departments, Christine Sinsky, MD left lasting impressions with her presentation on the ways changes in practice can actually help keep family physicians working and happy in their jobs.[5] Stimulated by what more we can be doing in ADFM, our leadership has since been asked to consider how we can collectively take the challenges Dr. Sinsky presented and work together to improve our academic practices.

Several sessions continued our tradition of learning from each other. We had a practical panel on developing research infrastructure followed by discussion groups for those with all different levels of research development, noting that a common denominator to successful research in any department is having a culture of inquiry. The final session of the meeting focused on a variety of innovative compensation plans that exist in our departments. One of the themes which these sessions illustrated is that, despite the many challenges our Departments face, the solutions and/or effective ways to address the challenges are often within the room at our Annual Winter meeting.

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AFMRD Association of Family Medicine Residency Directors

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INFLATION OF FAMILY MEDICINE RESIDENCY APPLICATIONS

Last year, graduates from MD-granting medical schools in the United States applied to an average of 23.7 family medicine residency programs and interviewed at 11. This year, applications were projected to increase again to 25.8[1] (a 57% increase since 2009). During this same time period, allopathic family medicine graduate medical education (GME) positions offered through the National Resident Matching Program (NRMP) have increased 18% from 2,730 positions in 2011 to 3,216 positions in 2015; fewer than one-half of these positions were filled by US MD seniors.[2]

The increased applications per residency slot are creating a burden on residency programs as they strive to adequately review applicants. This congestion in the application review process may also lead to some applicants being overlooked. The NRMP 2014 Program Director Survey reported that at least 80% of family medicine program directors are reviewing the following: USMLE step 1, 2, and CS scores; MSPE; family medicine letters of reference; personal statement; and the perceived commitment to our specialty. Interestingly, a Best Evidence Medical Education (BEME) systematic review found low to moderate correlation of grades, step scores, and LOR with post graduate training performance.[3]

Why is this happening? The AAMC Careers in Medicine "Apply Smart for Residency" video tells students via a looming bar graph, "Residency slots aren't growing at the same rate as graduating medical students. So, an already complex and competitive situation has become even more complex and competitive." Unfortunately, there is not huge competition for family medicine residency spots among US MD seniors and this increase in applications has not resulted in a significant increase in students choosing family medicine. From 2011 to 2015, there was an increase of just 105 US seniors matching into a family medicine residency program.[2] Additionally, the video statement made by the AAMC is not accurate according to Mullan et al. who report that the GME system is proving responsive to the increased output of US medical students and that there is *not* a shortage of GME spots.[4] The AAMC data also suggests that the unmatched rate for all US students has remained unchanged for the last 5 years, around 3%. Weissbart et al found no improvement in the match rate when students submitted an increased number of applications.[5] Despite this data, students perceive more competition and are applying to more programs and some are being counseled to use family medicine as a "backup plan."

This influx of extra applications from US students choosing family medicine, when there were more than twice as many family medicine GME positions offered last year than US MD students that were matched into family medicine, is unreasonable and unsustainable. Sifting through increased applications is not a productive use of a program director's time when there are increasing demands from ACGME around curriculum and milestone assessments. One possible solution would be to advocate for a limit on the number of applications per student. Another would be to educate students on the facts about matching into family medicine, eliminating some of the fear that is driving this change. We can promote a more holistic approach and ensure residency programs do a better job marketing what they are seeking in an ideal candidate, as well as assisting students in being more specific in identifying what type of program they are seeking. Lastly, we can advocate for social accountability and work more closely with our medical schools in encouraging more students to choose primary care as a career.

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Todd D. Shaffer, MD, MBA, FAAFP;
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