Length of Training Debate in Family Medicine: Idealism Versus Realism?

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Abstract

How long a resident must train to achieve competency is an ongoing debate in medicine. For family medicine, there is an Accreditation Council for Graduate Medical Education (ACGME)–approved proposal to examine the benefits of lengthening family medicine training from 3 to 4 years. The rationale for adding another year of residency in family medicine has included the following: (1) overcoming the effect of the duty hour limits in further reducing educational opportunities, (2) reversing the growing number of first-time takers of the American Board of Family Medicine primary board who fail to pass the exam, (3) enhancing the family medicine training experience by "decompressing" the ever-growing number of Residency Review Committee requirements to maintain accreditation, and (4) improving the overall quality of family medicine graduates.

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The President of the American Board of Family Medicine (ABFM), James Puffer, MD, carefully articulated the position of the ABFM in favor of extending training. Dr Puffer has noted the "lack of consensus" between ABFM leadership and some of the major stakeholders in family medicine: American Academy of Family Physicians, Society of Teachers of Family Medicine, and Association of Family Medicine Residency Directors. The ABFM has earmarked funding over the next few years to carefully examine outcomes in the current training programs that currently have 4-year curricula and those that submit applications to pilot 4-year family medicine residency programs. Using the "innovations" tract, the ACGME has approved pilots in some 20 to 50 additional sites, increasing the sample of graduates of 4-year family medicine programs. Currently, there are 12 program submissions under consideration.

A program director colleague asked me whether, given an additional year of funding to expand training for the residents in my program from 3 to 4 years, I would expand the length of the program. Honestly, I would relish the opportunity to have an additional year of training to decompress all the current training requirements. From an educational perspective, more time in a protected residency setting could provide additional clinical exposure and opportunities for enhancing practice management skills, procedural skills, and obstetrics and critical care training. As an educator, it is hard to imagine a scenario of "too much" education. That said, I am all too aware that there is a growing mismatch between scope of training (in residency) and the actual scope of practice of my graduates because most choose a narrower scope of care than is envisioned based on current family medicine program requirements.

It is important to examine all sides of this important issue, and that makes it difficult to ignore some of the real issues at hand. First, with a growing shortage of primary care physicians, family medicine physicians are needed immediately in the United States to address an impending workforce shortage.[1] Second, there is an increasing debt burden for most medical school graduates entering residency training.[2] Under a 4-year training model, debt will be exacerbated by the substantial opportunity cost of the family medicine graduate losing a year of family physician income. Third, currently, no other primary care disciplines (pediatrics, internal medicine) are considering expanding training to 4 years, potentially putting family medicine at a competitive disadvantage in recruiting medical students. In fact, it is reported that some primary care disciplines are considering shortening training to a 2-year initial training period. Fourth, the substantive costs of adding an additional year to family medicine training come at a time when the focus of governmental payers appears to be on reducing, not expanding, graduate medical education funding. Fifth, physician income disparities presently exist between primary and subspecialty care, with few signs of substantive improvement in the future and no expectation that they would be affected positively by lengthening family medicine training. Sixth, there is the current absence of a planned standardized curriculum that would complement the existing 3-year curriculum and meaningfully add to the quality of graduates.

The impact that expansion of training would have on recruiting current, US medical school graduates

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contemplating careers in family medicine education is largely unknown. Further examination of the benefits of a 4-year training length may produce evidence to support a hybrid model, where both 3- and 4-year ACGME-approved training programs coexist. Despite increased interest by highly qualified medical students in the small number of unique programs offering a 4-year curriculum, it is possible that a unilateral increase in training duration by all family medicine residency programs (and no lengthening of training in other primary care disciplines) could shunt qualified debt-laden US medical school graduates into other medical specialties, thus negating the desirable effect of improving the quality of the graduate family physician workforce.

In the absence of sufficient compelling data to justify extension of training, funding to study this futuristic initiative by the ABFM is laudable. However, it raises the question about the control group for such an experiment. If the outcomes of 4-year residency programs will be scrutinized in great detail, what group of graduates will serve as the comparison group? Graduates of current 3-year programs will not have an additional year of training, and it does not seem feasible for the experimental programs to randomize trainees to either a 3- or a 4-year program. The lack of a control group in most of these programs may result in erroneous conclusions due to a classic Hawthorne effect, in which people tend to work harder and perform better when they participate in an experiment of this nature.[3] One would naturally expect the graduate of a 4-year program to excel in measures over a graduate from a 3-year program. How much excellence must a 4-year trainee have over his or her 3-year counterpart to rationalize the time and opportunity costs of the additional year?

From a realistic perspective, extension of training is a costly solution to a problem for which there may be a less-costly answer. If quality of graduates is the major concern, then reforming family medicine training to enhance the quality of graduates could be accomplished by improving already existing current curricula, including the evolution of common curricula that could be implemented nationwide. A unified, shared curriculum in family medicine training still does not yet exist. The Family Medicine Digital Resource Library could be one means of disseminating and sharing a high-quality curriculum.[4] More, however, could still be done. Currently, there are no uniform competency-based standards for evaluating family medicine graduates. The Milestone Project for family medicine is nascent. Put succinctly, convening educators to develop an exemplary, standardized curriculum, with competency-based evaluations that could be applied uniformly across training programs, could be a less-costly alternative than extending the length of training.

For residency programs to fund a fourth year, a budget-neutral solution that has been proposed is to reduce the program's graduation complement. For example, an 8/8/8, 3-year program could convert to a 6/6/6/6 resident complement, thereby maintaining the resident GME "cap" on the number and funding of training positions. This solution would, however, reduce the output of family medicine graduates even more than would simply increasing the length of training in an existing configuration.

Perhaps underlying the length of training debate is some element of desire on the part of the family medicine community to seek greater legitimacy in the eyes of the ACGME and our subspecialty colleagues. That is, by extending training, our discipline would demonstrate a sincere interest in increasing the educational integrity of our profession and enhance the preparedness of family medicine graduates for quality improvement and other currently valued skills. Such a hypothesis does play into the underlying premise that family medicine is currently not succeeding in its approach to resident education, that its current training methodology is inherently deficient. As Eleanor Roosevelt said, "No one can make you feel inferior without your consent." There are many extraordinary practicing family physicians who are proof of the success of training in the specialty, given that their training occurred in 3-year programs. I think legitimacy in the eyes of the ACGME and our subspecialist colleagues will inevitably come from all those who recognize the value family physicians (and members of other primary care disciplines) contribute to reducing overall health care costs and increasing life expectancy in the United States.[5]

Like other family medicine educators, I strongly desire our discipline to prosper and to present some realistic solutions to the current health care crisis that is being exacerbated by a shortage of primary care physicians. Even with restricted duty hours, many acknowledge we can improve our existing 3-year training programs. Developing a uniform, standardized curriculum in family medicine education, with published Milestones for the ACGME competencies that are adaptable across residency training sites, would be a start in the right direction. Because of the substantial costs of extending training, which can be measured in both dollars and reduced workforce output, along with the proposal's largely unpredictable impact on US medical graduate recruitment, I sincerely believe that expanding to a fourth year of training is not a means toward that end.

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