False Assumptions

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(Fam Med. 2020;52(6):393-4.)
doi: 10.22454/FamMed.2020.518164

Based on decades of study and experience, we know a lot about primary care. For example, we know that it is the foundation of most of the world's health care systems[1] and we know that it is associated with improved population health and lower health care costs.[2] But this knowledge is based on certain assumptions about primary care's characteristics. We assume that primary care implies individual trusting relationships between patients and those who care for them, and we assume that a comprehensive scope of service allows primary care providers to care for a high percentage of health problems in the community.[3] Assumptions are tricky. We cannot prove they are true; we assume they are true. When an assumption can be proven true, it ceases to be an assumption and becomes knowledge. But when an assumption is false, the knowledge that is based on it is called into question.

As medical educators, we have always assumed that residency programs in family medicine, internal medicine, and pediatrics share a common goal to produce graduates who deliver primary care after completing their training. That is why we call them primary care disciplines. Patricia Carney, PhD, and colleagues challenge this assumption in this issue of *Family Medicine*. The Professionals Accelerating Clinical and Educational Redesign (PACER) study examined 27 primary care residency programs in nine institutions.[4] The study's aims were to foster collaboration among internal medicine, pediatrics, and family medicine residency continuity clinics, report resident exposure to team-based care, estimate career choices in program graduates, and identify factors enhancing and hampering interspecialty collaboration in primary care residency education. Much of the funding for the study came from the certifying boards in family medicine, internal medicine, and pediatrics. The nine PACER sites were selected after an application process that examined institutional interest in primary care practice redesign and commitment to collaboration with other professions such as nursing, physician assistant, pharmacy, and behavioral health programs. The investigators used a mixed-methods design including surveys, in-person interviews, and site visits. Eighty-nine percent of family medicine residents, 59% of internal medicine residents, and 67% of pediatric residents were exposed to comprehensive colearning in their continuity clinics and 87% of family medicine residents, 12% of internal medicine residents, and 37% of pediatric residents chose to enter primary care practice after completing their residency.

These results are dismal if our shared goal is to produce a primary care workforce. They are particularly disappointing considering that all of these training programs had sufficient interest in primary care to apply to be in the study. More than one-third of the internal medicine and pediatric residents were not even exposed to colearning in the clinic. The authors report barriers to collaboration in the paper's Table 3. Apparently, these barriers were substantial indeed! The study also identified significant stress in these residency programs and found important differences in how much primary care was perceived as a priority among them. Finally, the study found that its participants tended to underestimate the difficulties inherent in such collaboration.

PACER did not study collaboration between family physicians, general internists, and general pediatricians. Instead, it studied collaboration between residencies in the three specialties that train them. This distinction is important. General internists, general pediatricians, and family physicians share a commitment to primary care. But internal medicine and pediatric residencies are actually designed to prepare graduates for subspecialty fellowships and hospital practices, and they do this task well.[5] Family medicine residencies are far from perfect, but the differences in outcomes could not be clearer.

American physicians practice primary care in three distinct models; but are there really three effective models of primary care residency training at this point in the history of American medicine? PACER suggests not, so maybe it is time to consider more radical ideas. Perhaps internal medicine and pediatric residents who are interested in primary care could be assigned to complete primary care training in family medicine clinics. Perhaps primary care fellowships should be created in family medicine departments for internal medicine and pediatric graduates interested in primary care. Maybe the three disciplines should collaborate to reinvent primary care residency training from the ground up. But would these ideas really work? Family physicians care for patients of all ages and this is not the case for general internists or general pediatricians. Family physicians tend to believe that primary health care should be organized by family unit and should be rooted in the community being served. Internal medicine and pediatrics are founded on the idea that medical education should be focused on the individual patient and organized around their individual medical problems. In truth, our assumptions about primary care differ in important ways. Given these philosophical differences, it is easy to see why participants in this study encountered so many barriers to effective collaboration. If our goal is to produce a primary care workforce, it is time to admit that our graduate medical education system is failing the country, even if doing so would fly in the face of a century of tradition in how physicians are trained after medical school.

The founders of our nation proclaimed certain truths to be self-evident in the Declaration of Independence. They openly stated their assumptions in the document's preamble. That we have three primary care medical disciplines, and that we should celebrate diverse approaches to the educational process have been considered self-evident truths since the founding of family medicine 50 years ago. Today, these truths are no longer self-evident. Today, 50 years of history is telling us that the three approaches to primary care residency education are far from equally effective. Primary care faces an existential crisis. We can choose not to talk about this, but we make this choice at our peril.

References

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