

Quality Before Quantity

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We cannot solve our problems with the same level of thinking we used when we created them. —Albert Einstein

On March 19, the 2021 results of the National Resident Matching Program will be announced.¹ Each spring, we scrutinize every detail of the Match results,² but this year's process has been different due to disruptions from the COVID-19 pandemic. Medical student access to away rotations at potential residency sites has been severely curtailed and virtual interviews have replaced the traditional recruiting visits by residency applicants.³ So this year we are more anxious than usual about the Match and more uncertain about our goals for it.

In 2014, the Family Medicine for America's Health (FMAHealth) initiative brought together eight national family medicine organizations to reinvigorate family medicine for the future.⁴ One FMAHealth tactic team articulated a shared aim, known as 25x2030, to "... increase the percentage of US allopathic and osteopathic medical students choosing family medicine from 12% to 25% by the year 2030."⁵ In this issue of *Family Medicine*, Alan David, MD, questions whether this goal is achievable.⁶ Between 2010 and 2020, the number of family medicine residencies increased from 454 to 706, the number of first-year positions offered increased from 2,608 to 4,662, and number of positions filled by all types of applicants increased from 2,384 to 4,313. Despite these increases, David calculates that to achieve 25x2030, an additional 3,790 graduates would need to match in family medicine annually, an increase of 88% in just 10 years. He suggests this goal "is probably unrealistic... and

too limiting in terms of getting to a robust primary care workforce in this country."

We agree. The goal of attracting 25% of medical school graduates is unrealistic because the family medicine residency, as currently constructed, does not appeal to enough medical students, and it never has. At no time in family medicine's 50-year history have we ever attracted 25% of allopathic medical students into family medicine. There was actually a *decrease* of 60 matched allopathic students in 2020 compared to 2019.² The net increase of 487 matched students reflects an increase in osteopathic (475) and international medical graduates (78) as the osteopathic match was discontinued.² Traditionally, we have blamed lagging student interest on medical school admissions (who gets into medical school), the medical school curriculum (what and how they are taught), and the practice environment of American medicine. Continuing to rely on this traditional approach reminds us of the old story of the man looking under a lamp post for his lost keys because "this is where the light is." We emphasize medical school admissions and curricula because these are familiar, they are what we see in front of us.

In 2014, Jeri Hepworth, PhD, and colleagues described four pillars for primary care physician workforce development: the premedical school pipeline, the process of medical education, practice transformation, and payment reform.⁷ Although the first two pillars remain essential elements, the third, transforming practices, is critical to student choice,

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and may only be achieved by accomplishing the fourth, fundamental payment reform. Currently about half of family physicians report symptoms of burnout,⁸ a problem exacerbated by the COVID-19 pandemic.⁹ We live in difficult times. Despair is every bit as contagious as the coronavirus and we will need just as much concerted effort to control it. It is simply inconceivable that we can attract a quarter of the nation's medical students if they see unhappy, burned-out family physicians in their own communities. Knight postulates that the most pressing failures of America's health care system are also factors that dampen student interest in family medicine, including corporate medicine and fee-for-service payment.¹⁰ The primary care boards and specialty societies have come together recently with an unprecedented, unified call for payment and regulatory reform to stabilize and strengthen practice.¹¹ We need to match these national advocacy efforts at the local level, in every clinical practice, every medical school, and every residency clinic. In effect, we need to improve the public image of our specialty, something we can only accomplish by delivering care that is visibly more valuable to those we serve.

Consider for a moment what our specialty's "brand integrity" looks like today. By "brand," we do not mean just name recognition, but rather how we are perceived by medical students (and perhaps the public at large). Integrity implies a consistency between values and action. In the case of family medicine, students too often see a gap between our stated values and the reality of our practices. Our stated values emphasize accessible, continuous, comprehensive, coordinated, person- and community-centered care, but is this what they see today? Are patients able to choose and stay with the family physician of their choice? With more and more family physicians excluding inpatient care, maternity care, care of children, or working in focused settings such as urgent care or sports medicine, do students see us delivering comprehensive health care using the full range of a physician's capabilities? When medical students see health systems increasingly hiring advanced practice clinicians (PAs, APRNs) rather than family physicians, can we blame them for wondering whether completing 7 years of training to enter such a market is worth the trouble? While we can certainly work to transform practices, and advocate for large-scale health system reform, much of this is beyond our immediate control as faculty members, and fundamental change is slow to

come. To wait for large-scale system change ignores the seriousness and urgency of our current predicament. So, we must add to the four pillars, and create a fifth: to transform our residency education model.

What changes can we make to residency education that will excite future family physicians and allow our discipline to move into a new era? The process of answering this question has already started. The American Board of Family Medicine and the American Academy of Family Physicians hosted a national residency summit in December 2020 to provide input to the upcoming major revision of the Accreditation Council for Graduate Medical Education (ACGME) requirements for family medicine residencies. New requirements are currently being written with implementation expected in 2022. A special issue of *Family Medicine* will publish papers arising from this summit later this year. But this needs to be a local as well as a national effort because we have considerable control of how our own residencies work. We need to create programs that will attract America's best medical students, those who could match in any specialty they choose. Attracting such students to family medicine requires increasing the quality of our training and the first step toward doing this will require us to finally agree on what the family physician of the future should be; we need to agree on our national brand.

It is time to move beyond emphasizing the number of students selecting family medicine and the number of residency programs as the primary paths to salvation. For 50 years, we have worried about how many family physicians we can train. It is time to shift our focus to training family physicians to practice at the top of their abilities in practices that more clearly deliver value to their communities. Our brand matters, and we need to aim high in defining it. This starts with being the best physicians American medicine has to offer. Student interest will follow when they see family physicians as the most skilled, successful, and happy doctors they encounter. But that is not currently what they see because that is not currently what we are.

Twenty-five by 2030 is simply not a meaningful goal. It places our attention in the wrong places when we should be rooting out despair and setting a new standard of excellence in clinical practice and residency training. We will attract the best students into family medicine when we are the best physicians they encounter in their training and when their

own family members are sick. Our residencies must provide the best training in American medicine, not just offer more first-year positions. Quantity follows quality, and not the other way around.

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