Incorporating Telehealth Into Family Medicine Training: An Emerging Need

TO THE EDITOR:

I want to thank Dr Kahn for challenging family medicine residencies to measure their success in meeting the needs of our patients and improving care through the lens of the triple aim.[1] Additionally, Dr Kahn highlights the need to incorporate telehealth to fulfill continuity principles for our family medicine residents. This is particularly important in the post-COVID pandemic world. To best support continuity and continue to meet the needs of our patients in the spirit of the triple aim, we need to provide intentional telemedicine training to family medicine residents. Intentional telemedicine training is key to enhancing patient experience, improving outcomes, and reducing waste in the virtual world as well.

COVID-related social distancing to protect patients led to a rapid upscaling of telemedicine services across the United States.[2,3] Primary care, specifically family medicine, played a vital role in both expanding services and maintaining the quality of care our patients deserve. Up to 73% of primary care visits could be completed via telemedicine,[4] and both patients and providers are highly satisfied with telemedicine visits.[5] Providers and patients reported saving time,[5] clinical productivity has increased, and waiting list times and clinic no-show rates have decreased in clinics that have incorporated telemedicine services.[6]

If we expect residents to competently conduct telemedicine visits now and in the future, then we must develop intentional ways to teach trainees how to perform telemedicine effectively. STFM has recently released its telemedicine curriculum to work to address this gap.[7] At our residency program, preliminary needs assessment data demonstrated that one-third of residents and faculty did not feel confident that they could properly care for patients in telemedicine encounters at the onset of the pandemic. Interestingly, this was distributed across all levels of training, including attending physicians. Years of experience in practice did not translate into confidence with this new skill. Limited literature exists about interventions to educate family medicine residents on effective telemedicine encounters, but what does exist demonstrates that residents feel more confident after intentional training using telemedicine didactics and telemedicine handouts.[8] Using our needs assessment, our residency program is actively developing targeted resources to educate our current interns, residents, and attendings on how to have effective telemedicine encounters. These resources are taking two forms to meet the needs of our adult resident learners as well as experienced faculty physicians: asynchronous materials that can be reaccessed later for review, and the addition of a pocket resource for residents to utilize while performing a telemedicine visit as a quick reference.

Instituting telemedicine education as a pillar of residency education is family medicine's opportunity to meet the needs of physicians in 2021 and beyond. It promotes the triple aim of enhancing care experiences, improving outcomes, and reducing cost. Telemedicine is critical to ensuring continuity opportunities for our patients and resident trainees. Residency programs must be the change that Dr Kahn wishes to see and prepare the next generation of doctors for the future by providing dedicated and intentional training to residents on telemedicine encounters.

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References

1. Kahn NB Jr. Redesigning family medicine training to meet the emerging health care needs of patients and communities: be the change we wish to see. Fam Med. 2021;53(7):499-505. doi:10.22454/FamMed.2021.897904
2. Flattau A, Cristallo J, Duggan M, Gbur M, Fabienne Daguilh ML, Selwyn P. Clinical redeployment of an academic family medicine department in an early, severe COVID-19 pandemic in the Bronx, NY. J Am Board Fam Med. 2021;34(3):466-473. doi:10.3122/jabfm.2021.03.200562
3. Drake C, Lian T, Cameron B, Medynskaya K, Bosworth HB, Shah K. Understanding telemedicine's "new normal": variations in telemedicine use by specialty line and patient demographics. Telemed J E Health. Jan 2022:51-59. doi:10.1089/tmj.2021.0041

4. Jetty A, Jabbarpour Y, Westfall M, Kamerow DB, Petterson S, Westfall JM. Capacity of primary care to deliver telehealth in the United States. J Am Board Fam Med. 2021;34(suppl):S48-S54. doi:10.3122/jabfm.2021.S1.200202
5. Vosburg RW, Robinson KA. Telemedicine in primary care during the COVID-19 pandemic: provider and patient satisfaction examined. Telemed J E Health. May 17 2021. doi:10.1089/tmj.2021.0174
6. Murphy RP, Dennehy KA, Costello MM, et al. Virtual geriatric clinics and the COVID-19 catalyst: a rapid review. Age Ageing. 2020;49(6):907-914. doi:10.1093/ageing/afaa191
7. STFM Telemedicine Curriculum. Society of Teachers of Family Medicine. Accessed October 7, 2021. https://www.stfm.org/teachingresources/curriculum/telemedicine/telemedicinecurriculum/#24129
8. Ha E, Zwicky K, Yu G, Schechtman A. Developing a telemedicine curriculum for a family medicine residency. PRiMER Peer-Rev Rep Med Educ Res. 2020;4(21):21. doi:10.22454/PRiMER.2020.126466

Response to "Mistakes"

TO THE EDITOR:

I applaud Dr Saultz for exemplifying a growth mindset[1] in his powerful editorial about health care system mistakes made during the pandemic and the need to discuss them.[2] A growth mindset is crucial in constructively moving forward from failures. It is based on the idea that efforts matter and that everyone can grow through experiences. Growth mindsets focus on how to improve skills; they do not believe abilities are fixed or set. They are behind successful outcomes in a variety of fields.[1]

Dr Saultz delineates multiple areas of inquiry needing deliberation in order to learn from our mistakes in handling this pandemic. He also points out the problems arising from blaming others. Those with a growth mindset face their failures and become curious about them rather than blaming others, shaming themselves, or burying one's head in the sand. An interest in learning is what sets apart those with a growth mindset even when that learning requires difficult work.

The health care system has benefitted from exploring medical errors, but there is more work to do and cultural change is needed.[3] Furthermore, others have argued that adopting a growth mindset would bring positive cultural changes in medical education.[4] Family physician educators can facilitate the development of a growth mindset in students and residents. Two strategies go a long way: (1) challenging students and residents at a level that stretches them without breaking them, and (2) supporting learning without judgment or fear of failure.

Family physician educators with a growth mindset have high expectations of trainees while supporting their well-being in order to thrive. While high standards remain important to deliver quality care, it is important to acknowledge human limitations. For example, fatigue mitigation strategies address vulnerabilities associated with sleep deprivation. Furthermore, growth minded educators do not use disapproval as a primary pedagogical strategy. They understand that trainees are prone to error and provide tools, not humiliation, in order to close knowledge and practice gaps in trainees. Errors are expected and seen as opportunities to learn while under supervision.

In addition to improving educational outcomes,[1] a growth mindset may also be important in terms of the psychological consequences of medical errors. Family physicians who believe that medical errors mean they are bad doctors will struggle compared to those who see mistakes as inevitable learning experiences not to be repeated as Dr Saultz did early in his career. Without a growth mindset, the association between physician burnout, depression, and medical errors[5] may intensify. Family physicians using a growth mindset will learn from mistakes, deliver better care over time, and likely have greater work satisfaction.

Dr Saultz has outlined the collective failures during the pandemic in need of collective corrections. It will take collaboration, patience, and persistence to address them. Above all, it will take an eagerness to improve in mulitple areas. Who's ready to adopt a growth mindset to meet these extraordinary challenges?

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References

1. Dweck CS. Mindset: The New Psychology of Success. New York: Ballantine; 2006.
2. Saultz J. Mistakes. Fam Med. 2021;53(10):833-834. doi:10.22454/FamMed.2021.623606
3. Karande S, Marraro GA, Spada C. Minimizing medical errors to improve patient safety: an essential mission ahead. J Postgrad Med. 2021;67(1):1-3. doi:10.4103/jpgm.JPGM_1376_20
4. Theard MA, Marr MC, Harrison R. The growth mindset for changing medical education culture. eClinicalMedicine. 2021;37:100972. doi:10.1016/j.eclinm.2021.100972
5. Menon NK, Shanafelt TD, Sinsky CA, et al. Association of physician burnout with suicidal ideation and medical errors. JAMA Netw Open. 2020;3(12):e2028780. doi:10.1001/jamanetworkopen.2020.28780

Address White Fragility In Order to Engage in Racial Caucusing

TO THE EDITOR:

Guh et al demonstrated how a 90-minute experiential workshop on racial affinity caucusing (RAC) enabled participants to feel comfortable implementing RAC at their own institutions.[1] However, the authors acknowledge that their study's success may be attributed to a self-selected group of faculty who knew the potential impact of caucusing as a tool to address racial health inequities, and who were familiar with White fragility. In places where faculty are unfamiliar with the power of RAC, gaining familiarity with the realities of White fragility may be a prerequisite for an RAC workshop, and can be further explored in that space.

Robin DiAngelo coined and defined the term "White fragility," as "a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves."[2] Many White individuals admit that racism exists and needs to be addressed. But some, when you point out how they could be perpetuating racism, may become almost reflexively defensive. When White fragility is not acknowledged, racist behaviors and thinking can go unchallenged. This makes it difficult to implement systemic change and could cancel the gains from an RAC experience.

Many people of color (POC) are tired of having to educate leadership, colleagues, staff and friends on how racism manifests on numerous levels,[3] a toll known as the minority tax.[4] RAC shifts that responsibility by intentionally separating white individuals from POC. This allows the former group to explore White identity, privilege, and their role in racism, and the latter to focus on collective healing from negative racialized experiences. Ideally, RAC is initiated and supported by the highest levels of leadership—by leaders who are White and have confronted their own White fragility. Multilevel institutional awareness and acknowledgement of White fragility is pivotal to initiating the activation energy needed to implement RACs as well as sustaining the momentum needed to maintain these conversations in a safe space.

White faculty can prioritize time and resources to learn how to lead their respective RACs.[5] As DiAngelo recommends, conversations about Whiteness should start at the micro individual level of analysis and move to the macro institutional/societal level.[2] In addition, training materials and resources are available at crossroadsantiracism.org, raceandmedicine.com, racialequitytools.org, and at in the STFM Resource Library (https://resourcelibrary.stfm.org/viewdocument/toolkit-for-teaching-about-racism-i). We invite our White allies to use this knowledge to initiate RAC activities. As more of us implement, it will equip us with shared language to discuss racism, privilege, and other forms of oppression. In effect, we will be able to face them. In the immortal words of James Baldwin, "Not everything that is faced can be changed. But nothing can be changed until it is faced." Perhaps then, we can make progress in rooting out racism in our field.

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References

1. Guh J, Krinsky L, White-Davis T, Sethi T, Hayon R, Edgoose J. Teaching racial affinity caucusing as a tool to learn about racial health inequity through an experiential workshop. Fam Med. 10 2020;52(9):656-660. doi:10.22454/FamMed.2020.596649
2. DiAngelo RJ. White Fragility: Why It's So Hard for White People to Talk About Racism. Beacon Press; 2018.
3. Foster KE, Johnson CN, Carvajal DN, et al. Dear White People. Ann Fam Med. 2021 Jan-Feb 2021;19(1):66-69. doi:10.1370/afm.2634
4. Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? BMC Med Educ. 2015;15(1):6. doi:10.1186/s12909-015-0290-9
5. Michael A, Conger MC, Bickerstaff S, Crawford- Garrett K, Fulmer EF. Becoming an anti-racist White ally: how a White affinity group can help. Perspectives on Urban Education. 2009;6(1):4.

In Response to "Women Deserve Comprehensive Primary Care"

TO THE EDITOR:

I applaud Dr Barr's efforts toward reviving maternity care training in family medicine residencies. I agree that maternity care composes a unique feature of the specialty and challenges us to grow to meet the needs of our society.[1] To ensure our position as comprehensive care providers, family physicians need to increase access to maternity care and serve as mentors for trainees.

Family physicians can help expand coverage areas for obstetric services to reduce maternal mortality. The need for an enhanced network

of maternity care providers is evidenced by increasing maternal mortality in the United States.[2] Even without the incorporation of deliveries into practice, family physicians can help ease the burden of obtaining appropriate care with outreach clinics or shared care models where family physicians perform the majority of prenatal visits for patients that intend to deliver elsewhere. Various strategies exist to promote the incorporation of family physicians into maternity care, including developing interdisciplinary programs, supporting work-life balance, broadening training opportunities, and caring for the mother-child dyad.[3]

Many factors influence whether family medicine residents continue to provide maternity care, including time spent in maternity care rotations.[4] However, mentorship by family physicians during these rotations is equally important. A shortage of mentors incorporating maternity care into their careers will perpetuate a cycle of excluding these services from family medicine. The proportion of deliveries attended by family physicians has decreased since the change in ACGME Family Medicine Requirements in 2014.[5] The lack of available mentorship for maternity care is more dire in underrepresented minority family physicians. Family physicians who identify as Black/African American and Asian are less likely to provide obstetric care than those who identify as White, even when controlling for setting (rural vs urban).[6] Without diversification of the maternity care workforce, the disparities experienced by minority populations will only continue to grow.

Maternity care is woven into the fabric that is family medicine. By increasing access and providing mentorship, family physicians can help to meet the needs and challenges of obstetric care in America.

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References

1. Barr WB. Women deserve comprehensive primary care: the case for maternity care training in family medicine. Fam Med. 2021;53(7):524-527. doi:10.22454/FamMed.2021.451637
2. Hoyert DL. Maternal mortality rates in the United States. NCHS Health E-Stats. 2019;2021. doi:10.15620/cdc:103855
3. Goldstein JT, Hartman SG, Meunier MR, et al. Supporting family physician maternity care providers. Fam Med. 2018;50(9):662-671. doi:10.22454/FamMed.2018.325322
4. Tong ST, Hochheimer CJ, Barr WB, et al. Characteristics of graduating family medicine residents who intend to practice maternity care. Fam Med. 2018;50(5):345-352. doi:10.22454/FamMed.2018.631796
5. Fashner J, Cavanagh C, Eden A. Comparison of maternity care training in family medicine residencies 2013 and 2019: a CERA program directors study. Fam Med. 2021;53(5):331-337. doi:10.22454/FamMed.2021.752892
6. Eden AR, Taylor MK, Morgan ZJ, Barreto T. Racial and ethnic diversity of family physicians delivering maternity care. J Racial Ethn Health Disparities. 2021.. doi:10.1007/s40615-021-01055-y