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Family Medicine

PRESIDENT'S COLUMN

Our Scope Is Our Destiny

Joseph W. Gravel Jr, MD

AUTHOR AFFILIATION:

Medical College of Wisconsin Department of Family and Community Medicine, Milwaukee, WI

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Larry Green wrote a memorable commentary back in 2001 entitled "The View From 2020: How Family Practice Failed."[1] His thought experiment included:

> Family medicine didn't really fail. It abdicated... by relinquishing more and more services to others, family physicians garnered immediate benefits, such as apparent peace and relief from accusations of "not being a team player." In the specifics of specific places, it made sense to turn over the care of the dying, the newborn, the adolescent, the athlete, the discouraged, the pregnant, the bed-bound, the post-operative person—to someone else....But, the ultimate result of these adaptations was erosion of the functional domain until it lost its coherence, that essential totality that made it what it was.[1]

Discussion about scope of practice in family medicine in 2025 typically focuses on two things: (1) whether family physicians are doing inpatient adult medicine and/or maternity care, and (2) consternation about others' scope of practice—namely advanced practice registered nurses, physician associates, and pharmacists—and whether corporate health care will opt for what may appear on a balance sheet to be a cheaper alternative. Except in more rural areas, family physicians have generally given up inpatient care of children (as have many community hospitals) and adult critical care. Ambulatory care of children is also declining. More family physicians providing maternal health care could address worsening maternity care deserts[2] and a growing US maternal health crisis with rising maternal mortality rates.[3] A broad scope of practice benefits patients by providing greater access to services, lower hospitalization rates, and lower costs[4] while reducing family physician burnout.[5]

During the COVID-19 pandemic many family physicians transitioned back to inpatient care as that was the pressing need; it is unclear what happens when the next pandemic occurs, with even fewer family physicians comfortable with inpatient care. With little, if any, centralized health care planning that is apparently another problem for another time.

A third scope issue, however, gets relatively short shrift and in the long run may turn out to be equally important. The issue is *ambulatory* scope. Assuming there will not be a huge shift back into hospital care any time soon, how do we effectively train all family physicians to broaden their scope of practice in ambulatory clinical environments to reliably meet their patients' needs? Our scope of services is varied enough that patients often default to specialty care because they often don't know what to expect from us. If we can't agree as a specialty, it will be others who determine our graduates' scope of practice even more so than now.

It has been over 20 years since the Future of Family Medicine (FOFM) Project was developed to strategically renew and transform our specialty. Starting with five task forces covering different strategic areas, a sixth focusing on financial reimbursement was formed to facilitate the recommendations of the other task forces. Task Force 2's focus on training stated in its final report that "it is clear that the traditional family medicine curriculum, although successful in the past, cannot meet the anticipated needs of the health care system of the future."[6] The FOFM Project envisioned a new model of care that included the patient-centered medical home, electronic health records, electronic scheduling, and use of email communication as well as electronic access to practice guidelines and medical information resources.

The dawning of the artificial intelligence (AI) era now echoes this initial electronic age in medical education. The 2023 Accreditation Council for Graduate Medical Education (ACGME) program requirements for family medicine reflect a thoughtful response to clinical practice, technological, and societal changes that have occurred and are still in active evolution. Many of the same themes, our specialty's generally unchanged cultural values, and many of the same educational concepts are expressed in both the Program Requirements and the FOFM Report documents despite being written 20 years

apart. We thus already have a foundation upon which to build a new model providing a broadened, standard, consistent scope of ambulatory practice.

Current ACGME program requirements[7] provide residents more curricular choice by doubling the previously required 3 months of elective experiences to requiring 6 months. The requirement states electives should be driven by each resident's individualized education plan to address the needs of future practice goals, developed with the guidance of a faculty mentor, and evaluated. The "background and intent" section states that these elective experiences are critical *to best serve the resident's future communities* (my emphasis). If real-world application of this guidance and oversight responsibility becomes a rubber stamp for 6 months of "choose your own adventure," we will have inadvertently trained for a more limited scope of practice. Over 20 years ago Robert Phillips and Larry Green wrote, "It is essential that decisions about the domain of family practice be grounded in assessments that move beyond (physician) perspectives and focus on how choices about the domain of family practice affect patients."[8] This is true now more than ever.

Areas of concentration, tracks, and individual electives need to produce "enhanced generalists" rather than "partialist-lite" physicians with diminished scope of ambulatory practice. Residency programs should strongly consider a "selectives" approach to elective time in which patient need-centered options are presented. Residents should be reminded that their first job in their first community will probably not be their last. Striving for a broad scope of practice in residency is in their best career interest regardless of their initial job plans. Residents who believe they are training for an urgent care position may find a future practice landscape very different from what exists today.

Besides continued efforts in providing more training in the care of infants and children, a specific ambulatory scope-broadening example based on community need is enhanced training in the care of older adults. The demographic trends are incontrovertible. Many of our residents in their 20s and 30s do not have a particular interest in caring for ambulatory older adults, yet this is where the growing need is and will be. Medication assisted treatment (MAT), point-of-care ultrasound (POCUS), enhanced use of AI, treatment of obesity, and office-based procedures are other examples of ambulatory scope that need to be standard, not optional. Despite their frequency, musculoskeletal conditions still get inadequate attention in most allopathic medical school curricula and in many of our residencies; enhanced competency (regardless of resident interest) could be more of a positive differentiator from other primary care clinicians. The significant need for strong behavioral skills has been covered in previous President's Columns. The ability to work with public health or population health offices, information mastery skills (in an era of governmental misinformation), telehealth skills, use of biometrics, and personalized medicine and use of patient genetics will grow in importance, regardless of residents' personal interests.

Advocacy plays an important role in determining scope on the individual physician, practice, and system level. Anastasia Coutinho and colleagues identified a discrepancy between graduates' scope preparation and what the marketplace was offering.[9] Advocacy and negotiation skills need be taught to confront this with prospective employers, specifically teaching assertiveness for desired scope in job negotiations. Residency family medicine practices must actively support a broad scope of practice[10] through their operations, facility usage, and faculty role modeling to provide its graduates the confidence to push for this. Family physicians in practice types commonly associated with large health systems have narrower breadth of practice; policy makers can encourage payment models that incentivize broader scope.[11]

Much of the problem is not extrinsic however. How do we motivate all learners to provide a broad ambulatory scope? Role modeling is most important. Continued focus on inculcating relationship-based care in our teaching practices rather than capitulating to our systems' transactional approach helps motivate a broader scope. It is more difficult to be disinterested in MAT when your continuity patient has a life-threatening addiction issue. Rather than, "I want to provide that service," it becomes more a matter of, "I want to provide that service *for my patient who needs it.*"

Better measurement of referral patterns of our learners would also be helpful to provide them useful feedback and address weaknesses in ambulatory scope. Learned helplessness and overreferral need be challenged in our daily precepting encounters.

Joshua Freeman has commented, "If our scope of practice as family physicians is changing and becoming more narrow, it is not because of NPs and PAs; it is because we either want it to be or we are unwilling to stand up to those who are narrowing it."[12] As educators we need to stand up, and help create a workforce that can and will do so also. If not, Larry Green's warning remains a possibility: "Family medicine didn't really fail. It abdicated."

The ball is in our court.

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