

Collaborations Versus Missions

Joel J. Heidelbaugh, MD

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To the Editor:

I greatly appreciate the spirit of Dr Snellings' recent letter,¹ namely the request for collegiality and the sense of urgency regarding health care provider shortages in primary care. However, the letter misses the mark when as it does not posit a single solution or challenge for how family medicine and internal medicine should "take the lead in renewed collaboration efforts." Indeed, numbers of family physicians and general internists are in decline, many work part-time (which, while I wholeheartedly support this option, does impact the workforce). It is a true tragedy that we will only partially replace nearly a generation of general internists aged 45 years and older in private practice. According to the American Board of Internal Medicine, over two-thirds of internal medicine residents do a subspecialty fellowship; of the remaining one-third of residents, over half will become hospitalists or work in urgent care. The myth that advanced practice providers will replace primary care providers in the ambulatory care setting has not and will not come to fruition; we need more of us, and we need more of them, collaboratively. Academic circles continually lament their struggles to hire general internists to work in the outpatient setting often despite large financial incentives. Moreover, we do not possess clear data on the impact of those physicians who completed residency in the combined internal medicine-pediatrics programs, which when conceived was aimed at bolstering the primary care workforce.

Academic family medicine has risen above its challenges in creating stand-alone departments to foster primary care, yet since it became a definable medical field in 1969 there are still over a dozen orphan medical schools that do not have a department of family medicine. Harvard University Medical School, a member in the original pilot for 15 family medicine residency programs, does not have a department of family medicine. George Washington University School of Medicine and Health Sciences recently created a division of family medicine, housed within the department of emergency medicine.

While I agree that family medicine "should take the lead," I'm not quite convinced that "building a vigorous, multispecialty coalition" would solve our workforce dilemma. I do believe in the adage "strength in numbers," and have grave concerns about how our country is going to have an adequate supply of primary care providers to care for our aging population. The major challenge I foresee in "joining forces" would disavow the inherent philosophical differences between family medicine and internal medicine. If the solution is to create an umbrella of care spanning the lifecycle and population, isn't that what family medicine already is?

Our collective challenge to bolster the primary care workforce starts within the medical schools—to define their missions, which would hopefully be centered on provisions for primary care and community-based medicine, that should then drive both admissions practices and internal cultures. Literature abounds regarding reasons why students do not choose a career in primary care (eg, debt, prestige, reputation, etc). As Dr Snellings highlights, the family medicine match won't solve our primary care shortage. It is the positive marketing of the greatness and opportunities within the unique careers of family medicine and general internal medicine, as well

as general pediatrics, coupled with mentoring and a dramatic culture shift in acceptance of these fields, that will drive students to pursue primary care. Our collaborations can occur in unison, yet our missions and efforts should remain separate.

Author Affiliations

Joel J. Heidelbaugh, MD - Departments of Family Medicine and Urology, University of Michigan, Ypsilanti, MI

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