2026, Volume 58, Issue 3, 247-248, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

# Response to "The Primary Care Workforce Is Transitioning Away From a Physician-Dominated Model"

**Joseph Gravel, MD[a]; Wendy B. Barr, MD, MPH, MSCE[b]; Grant Hoekzema, MD[c]; Jay Fetter, MSHA[d]; Alan Douglass, MD[e]**

AUTHOR AFFILIATIONS:

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

[b] Yale Family Medicine Residency Program, Yale University School of Medicine, New London, CT

[c] Department of Family Medicine, Mercy Hospital, St Louis, MO

[d] Residency Redesign Initiative, American Board of Family Medicine Foundation, Lexington, KY

[e] University of Colorado School of Medicine, CU Anschutz Medical Campus, Denver, CO

CORRESPONDING AUTHOR:

Joseph Gravel, Department of Family and Community Medicine, Medical College of Wisconsin, Milwaukee, WI, jgravel@mcw.edu

HOW TO CITE: Gravel J, Barr WB, Hoekzema G, et al. Response to "The Primary Care Workforce Is Transitioning Away From a Physician-Dominated Model". *Fam Med.* 2026;58(3):247-248.
doi: 10.22454/FamMed.2026.249527

FIRST PUBLISHED: March 5, 2026

© Society of Teachers of Family Medicine

## TO THE EDITOR

Dr Mainous' recent guest editorial[1] states, "Rather than asking the question, 'Is a 4-year residency better than a 3 year residency?', it might be more useful to ask, 'Where does the family physician fit in the new world order and how do we keep family physicians relevant?'"

As educators with decades of experience with 4-year family medicine training models, we believe he is asking precisely the right question.

We have been impressed over the years by the apparent assumption of those advocating for the status quo (others who are more sanguine or don't agree we are on a burning platform) that our hyper-capitalistic market-based health care system will inevitably continue to prefer utilizing a higher cost labor force over cheaper, more quickly producible alternatives for apparently the same services.

Advocates for addressing the length of training are motivated to improve training so that we can better differentiate family physicians from lesser-trained clinicians. The profit-driven health system is finding it more and more difficult to see any meaningful difference. The question to ask about the length of training is, "What is the training time needed to produce a clearly superior primary care clinician that is worth the additional cost?"

A related important question is, "What will differentiate a *well-trained* family physician armed with artificial intelligence (AI) from a less-trained clinician armed with AI?" Past wisdom may be helpful. Gayle Stephens wrote that family medicine is rooted in a unique intellectual, relational, and ethical foundation that goes beyond technical expertise and algorithm-derived care.[2] AI may process data, but it (at least for the foreseeable future) cannot synthesize biomedical, psychological, and social factors in real-world contexts—the patient's unspoken fears and concerns, family dynamics, the trust that comes from relationship building that is not enterable into AI. It cannot combine altruism with enough proficiency and expertise to go beyond a transactional, over-referring level. At their best, family physicians engage in moral reasoning, shared decision-making, and patient advocacy, addressing existential concerns and ethical dilemmas, which will still require human judgment and compassion. Viewing medicine as a reductionistic series of technical tasks ultimately shortchanges the public. Are our current training programs delivering effectively on pushing back on this stance by providing a clear alternative?

Using Mainous' analogy of the horse manure crisis (albeit apocryphal), most of our programs are doing the best they can with the time available to tweak the horse buggies rather than figure out how to build electric trains and automobiles. The production time is inadequate to do otherwise. Electric trains and automobiles are more complex, require greater technical expertise and initial expense, require other costs such as tracks, paved roads, and charging stations, and take more time to produce than a simple buggy. Concerns about the quantity of the primary care workforce—assuming this is mostly about family physician production—are akin to worrying about reducing horse buggy production.

As Mainous points out, the growing use of advanced practice providers and AI may help address the *numbers* for primary care workforce development, but we believe it does not address the quality of care or the impact on health outcomes. We have a core belief that continuing to produce the same type of physician, restricted by continuously diminishing

actual training time compared to the past, will ultimately be an untenable market niche for family medicine in most locations.

Skariah and other 4-year proponent colleagues "recognize the specialty is not yet ready to universally endorse [a 4-year model]. While we disagree with this hesitancy, we acknowledge the complexities of system-wide change."[3]

We hesitate at our peril. Calling for further study[4] in place of decisive, strategic action will not serve us, our patients, or our communities. The system will evolve with or without us.

## REFERENCES


1. Mainous AG III. The primary care workforce is transitioning away from a physician-dominated model. *Fam Med*. 2025;57(8):532–534. doi:10.22454/FamMed.2025.348227
2. Stephens GG. *The Intellectual Basis of Family Practice*. Winter Publishing Company; 1982.
3. Skariah JM, Weida N, Legere-Sharples K, et al. Response to "Impact of training length on scope of practice among residency graduates: a report from the Length of Training Pilot Study in family medicine". *Fam Med*. 2025;57(9):684–685. doi:10.22454/FamMed.2025.268733
4. Parente DJ. Extended duration of training, resident physician well-being, and the primary care physician shortage: questions remaining following the Length of Training Pilot. *Fam Med*. 2025;57(8):529–531. doi:10.22454/FamMed.2025.828115