Future Training of Family Physicians

Focus Group Report

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Future Training of Family Physicians
Focus Group Research Report

I. INTRODUCTION

A. PURPOSE OF REPORT & METHODOLOGY

The purpose of this report is to provide the results of the focus groups conducted to help shape the training programs for family physicians in 2040. The insights gathered from this research project will provide direction at community-wide dialogue at an upcoming national summit. More specifically, the focus group discussion addressed the following six questions:

1. What does society need from the family physician of the future?
2. What should we teach?
3. How should we teach?
4. How can residency education support graduates' ability to shift practices and populations over time?
5. What is the right balance between innovation and standardization?
6. How can we improve the social accountability of graduate medical education?

The methodology used for this study was virtual focus groups with a variety of audiences.

A total of 71 participants participated in the group discussions. Below is a profile of the participants.

Participants/Audience	Profile of Participants/Criteria	# of Participants
Family physicians (3 groups)	Spend the majority of their time direct patient care (minimal teaching or academic) Represented a cross-section of practice settings, geographic location, years out of residency, location of medical school, (US or international) medical degree (DOs or MDs), gender, etc.	25
Residents (3 groups)	PG2-PG3 Represented a cross-section of residents by gender, geographic location, medical degree (DOs and MDs) and location of medical school (US or international).	20
Medical Students (3 groups)	M3-M4 Represented a cross-section of students by gender, and geographic location.	26
Commission of Education (2 group)	1st group with active members 2nd group with students and residents No liaison members	4 4
RPS Consultants (1 group)		6

A few audiences were asked to read some background papers prior to the focus group discussion.

II. KEY FINDINGS

B1. *WHAT DOES SOCIETY NEED FROM THE FAMILY PHYSICIAN OF THE FUTURE?*

*Audience: Family Physicians and Commission on Education Members and b*ackground papers #10 - #14

Do you think the 4Cs should be updated to include a 5th Community of Engagement to address unmet health and social needs in your communities?
✓ Most of the participants agreed that the Community of Engagement should be added as the 5th C. ✓ A few echoed concerns that independent owners or smaller practices wouldn't have the resources or staff to address the unmet health and social needs in their communities. ✓ A few said adding this extra component of addressing their patients' social needs to their already busy schedule will attribute to physician burnout.

Positive - community engagement added as the 5C

- "Community engagement I think is a very good goal. It can be a double-edge sword however because it's sort of like with Covid right now. I've been a medical advisor on the board of health for many years and I got a lot of flak for trying to get mask mandates through our county when our governor wasn't able to do that. When I tried to speak against the school board - teaching creationism, I got a lot of flak. I know my involvement with the Boy Scouts has really been helpful and it helps fill your practice with people that are also community minded. But at the same point, it can develop some angst." *~Family physician*

- "Looking at bigger trends and trying to, in some sense, predict things that are coming or refocus efforts, I think family doctors are the ones that are the best suited to do that. So for that notion alone, that if we're the ones that is the quarterback for the team, the one that's aiming everything, that has the comprehensive look over the patient, then that leads very naturally to the patient's family and then the patient's neighborhood, to the global community that we serve which is our systems, our practices to do more to kind of impact some of those trends. And then we also have access to all this data. I know it's painful to get it out of our EMRs because they're painful to use and maybe one day we'll move to systems that are a little bit better for this. But that's how I look at this, more that population health management, that role, and how can we best teach that." *~Family physician*

- "I think it really resonates. I think it resonates with our specialty and I think it really resonates with the times. We have an opportunity, as well as arguably or inarguably, a responsibility to advocate. I think in the paper, the one page that you shared with us, a lot of attention does go to the care of the individual patient and of course as family physicians we do have often an opportunity to care for more than one member of the family and the truth is, we all exist in the context of the greater community and community engagement, and community health is part of our curriculum. I think this is significant for residency training programs, that is a significant aspect of how we should train our residents and adding it as a pillar just -- that commitment." *~Family physician*

Barrier: lack of resources and staff

- "I think there's a lot you can do on a community level. But I consider this a lofty goal, it's rather daunting. It's not that we don't need to address it. We do and we need to be part of that solution. But I can imagine my friends who are in private practice struggling to keep their doors open, this is just another thing added to their plate. Right now, we're just so focused on serving the patient population that we have and knowing that these other things affect our patients, but it becomes a little bit overwhelming. I mean I can only change so much. I'm fortunate because I have case workers in my practice, I have a social worker in my practice. I have a lot of people on our team that can help our patients with these types of issues especially when it comes to food insecurities or homelessness. So I think that's a start but it doesn't even really touch upon some of the pure overwhelming factors that play into a person's -- that area community-driven. It seems so overwhelming, I think, and so big that it needs more than just us to kind of help impact that. I think raising the awareness of that. And we're coming to do that now. In fact, I know in the EMR we have a section that's called Social Determinants of Health and it asks all these questions about transportation, housing, food, that sort of thing. But that's just the beginning, I think. And if that can be a part hopefully of our future family physicians to realize that impact, I think that's the first step. Absolutely I think it should be included, it should be included because definitely we know that's their health." ~Family physician

Barrier: trigger burnout because of the lack of resources

- "I think the paper that was sent out put a lot of emphasis on the social determinants of health and I think unfortunately that sets us up for burnout because as a family doc, I have very little power and very few resources, honestly, to get you food stamps, to get you housing. I don't have any power over that stuff. I think you're setting docs up for burnout if you say that we have to be responsible for every aspect of their social situation. Maybe, I don't know, separate some of that out into a fellowship where you do political action to fix things like housing and food disparities and that kind of stuff. I think that would be better than making the rest of us feel completely incompetent because I can't get you food stamps." *~Family physician*

How should telehealth or virtual care fit into the continuity of care and coordination of care?
✓ Many believed that telehealth services and urgent care do fit into the continuity of care and coordination of care. ✓ However, a few of the more experienced family physicians had some reservations with urgent care being part of continuity of care. They felt it would negatively impact continuity of care by the deflection of care being contributed to patients using urgent care over primary care.

Telehealth services will continue and is represented in the 4Cs

- "I think telehealth is essential, especially with what's going on with the pandemic right now. That's the first contact sometimes, anybody's having with anybody, especially in the hospital. Just from a palliative point of view, I can't tell you how many times my fellows or I have called families that have loved ones in the ICU, intubated and they're saying it's the first contact they've even had." *~Family physician*

- "I think telehealth services are great teaching tools for probably every level of resident. But I think that's a great teaching tool with good mentorship. I can see the value of telehealth and urgent care. But I think we could probably make it more useful and I think the patients would appreciate it." *~Commission on Education*

Agree that urgent care is part of the 4Cs

- "A lot of times urgent care is integrated within a bigger system that still gives access to the patients within the system and their records can also be integrated so their actual primary care doctor can see it. So, yeah, absolutely it's part of the equation." *~Family physician*

- "I actually think urgent care can really extend our ability to have that continuity in ways that we haven't before as long as we can reach the communities that don't have great access to internet or reliable phone services. I think it can play a huge role. And just to add, family docs who work in urgent care are going to encourage their visits in a very different way and with that continuity mindset. And even if they're not providing the continuity themselves, they're definitely going to have a focus on making sure patients get that. So they're kind of a branch of continuity within the specialty and they play an important role." *~Commission on Education Member*

Do not agree that urgent care is part of the 4Cs

- "From my practice perspective, I consider a patient going to urgent care and in the vast majority of patients, to the ED, is a failure of good primary care." *~Family physician*

- "I don't see urgent care as part of continuity of care. In fact, it is a breakdown of the aspect of what family physicians do best." *~Family physician*

What should our approach be in training for comprehensiveness?
✓ The focus of training for comprehensiveness is to emphasize the different ways that family physicians approach comprehensiveness in the variety practice settings.

Highlight the different practice settings represented in family medicine

- "I think that the issue is really leading to comprehensiveness. So, it's not necessarily as much, for me, what you do as where you do it. If we design it as seeing patients in more than one setting, inpatient, outpatient, outpatient obstetrics, outpatient in nursing homes, outpatient hospice, something like that. I know everyone's got their own way. *~Family physician*

- "I think that's probably the one that is up for the most debate in what we define comprehensiveness as. As you see, those of us on this call today have varying levels of providing the type of care that we're trained to do. So, comprehensiveness, if I don't do the care, I provide or coordinate for that care for my patients. So, I think they all are still relevant today despite the changes in our practice types and the introduction of all the different forms of technology that we use." *~Family physician*

- "One the examples that I point out to my students in terms of comprehensiveness of care, even though I may not end up managing that patient's very odd condition that a specialist is managing, I still am the one that when they come to see me, I review all of their medications with them. And each of their specialists, and very complex patients see multiple specialists, sometimes four, five, six different specialists. Nobody but their primary care doctor is really sitting down with them and reviewing all of their medications with them and going over them with them, making sure they understand what's what, making sure they understand when they're following up and just helping them kind of navigate this complex medical system that we have. And you're the one that's doing that. I think we do function on teams more and more, which you have to out of necessity in order to take care of these complex patients. But you are the captain still of that team, in my opinion, and the primary care doctor should be the one in that role. So, I see that as part of our comprehensiveness. *~Commission on Education*

- "First of all, if you look at this group we're very, very diverse both in age and also what we do. Having practiced full scope, including C-sections, for thirty-two years, in a rural setting, is a whole lot different than being in an urban setting. And in an urban setting you can have an all-primary care setting, like I was in, which did not do inpatient or OB, or you can be in a large healthcare system where you become more and more of what I would call a traffic cop, always sending people off to wherever. So, we come from very, very diverse situations. And I think that we're going to have to train our residents in a way, depending on where they are and what they want to do. Ideally it is important that we are as comprehensive, and we have as much continuity and coordination of care as we can. When I was --, we were doing some things that were totally amazing. We were one of the top ACO's in the country out of 550 ACO's and we were saving one of our commercial payers $220 per patient per month and yet they're top quality. So, it can be done if you have this, but you have to have a big team around the physician. The physician can't do everything. And you also need to have really good analytics and maintain population health. All of those things are important." *~Family physician*

B2. *WHAT SHOULD WE TEACH?*

Audience: Residents and no background papers

Which clinical areas are so important in terms of function, morbidity and cost that all residents in the next 15-20 years must learn about them?
✓ The most common theme was additional focus on addiction, obesity, mental health, and procedural skills, especially training with point of care ultrasound. .

Clinical skills needed: addiction, obesity, mental and behavioral health, and diagnostic and surgical procedures

- "In terms of diseases, just looking back over the last ten years and really the rise in obesity, mental health disorder and looking at addiction treatment being something that all family doctors should be doing in a primary care setting. It's not a core competency at this point but I think it's something that we have a responsibility for communities to be doing." *~Resident*

- “Honestly, I think addiction medicine like she was saying earlier is one of the biggest things. We see that a lot in our family practice clinic here. I would say almost 30 to 35% of my panel is either undergoing pain management and/or they are already enrolled in the Suboxone clinic here locally in Alabama.” *~Resident*

- “One thing I’d like to see is more mental health emphasis. I think most family docs take care of the vast majority of people with mental health problems – which is appropriate in primary care. And I’m not sure that we receive adequate training. In fact, I think over the years it’s actually decreased.” *~Resident*

Diagnostic and surgical procedures

- “Just because everyone’s not going to go into community medicine or rural health or something like that so I think building up on those dermatologic procedures as well would be something that’s kind of good. Of course, we can freeze off warts and stuff like that but there’s other procedures that we probably could be doing that could help our -- as we step out on our own.” *~Resident*

- “I think point of care ultrasound is something that is becoming more and more common. And as the cost has come down incredibly over the last ten years or so, we’re seeing things like Butterfly and clinic ultrasound being a lot more available both for use in the clinic or in the hospital. And at least in my program we have a younger faculty member who is pretty skilled with ultrasound than a lot of our more experienced faculty who didn’t train for ultrasound are actually kind of limiting that because they’re not comfortable precepting those of us that have more ultrasound experience.” *~Resident*

- “I wish that we had more training in point of care ultrasound. None of our attendings have never really learned it and it’s like an emerging skill for a lot of primary care doctors. I know since I’m a third year I’ve been looking for jobs in a lot of places to encourage ultrasound, at least for residency -- training for radiology ultrasound.” *~Resident*

- “I would second the thoughts earlier about the point of care ultrasound. Our residency is working on fine tuning our point of care ultrasound curriculum. And as we start to look for jobs, look at contracts, our faculty is encourages us to add in some sort of ultrasound into what our future employers would provide, whether that’s a portable, handheld Butterfly or more of a permanent type, more extensive one in the clinic. But that, I think, has been beneficial and something that my colleagues and I need to continue to get better at.” *~Resident*

How much curricular flexibility should individual residencies and residents have to be responsive to local needs and residents’ interests?
✓ Residents echoed the need to have additional time to complete electives as way to have more exposure to out-patient practice settings. ✓ In addition to more time, several wanted the capabilities to tailor their electives to their interests. ✓ A few mentioned having tracks as electives (e.g., OB, rural health, FQHC, etc.).

Electives - more time and the availability of more options based on residents' interests

- "I think that family med is so broad spectrum that as you go through residency, you kind of figure out what you want to do and you want to tailor your electives and things that you like, throughout residency. *~Resident*

- "One of my complaints is that there's not enough elective time in the family medicine curriculum. We only have about, I think, three or three and a half months of elective time. And there are so many other electives that I would like to include in my training and I would rather do less OB and then more -- in rheumatology and other things that I would find more pertinent, like pain management, in my training. And additionally, we spend a lot of time with community medicine rotation and it's great to go out in the community with Barkley Wegg and all these other public services. But I would almost rather have an opportunity go to follow other physicians that are in private practice, that are doing DPC, rather than just the academic setting of learning in my residency. *~Resident*

- "I would agree with that. I think more elective time would be valuable because family medicine is such a broad field it's hard to have a one size fits all curriculum. And I think more elective time, especially in your third year when a lot of people already have a contract lined up and they already know what their job is going to be, being able to select electives that fill your niche would be more valuable rather than I know what my job is going to be but I have to do this NICU rotation when that's not something I want to work in, for example." *~Resident*

- "The need to sort of tailor training to the resident rather than the resident to the training. If someone's not interested in more OB training, then that should not be the expectation, for everyone to do 3 months of OB or X amount of OB. I feel like there should be a set requirement and family medicine lends itself to sort of choose your own path, sort of ordeal, so maybe incorporating more electives and less mandatory rotations that help residents sort of explore their interests rather than the interests of the program, is where I think the future of family medicine should go." *~Resident*

- "Yeah, I agree with that. To look over the different specialties and things like that, that we have to do. Like in my program we have to do ICU, two months of it. I'm never going to work in an ICU. I knew that from day 1. OB/Gyn as well. It's mandatory for two or three months in my residency. So, I wish we could do a little bit less of other things and focus more on what we want to do in the future. And I know that in my program we all have two weeks of health systems management. I wish we had more of that – like the different numbers hit, how many patients you have to see and what kind of goes on behind the scenes of a practice. I feel like we don't get much of the billing aspect of it." *~Resident*

- "Like we were saying before, instead of spending so much time on OB/Gyn, that time could be better used to the new, emerging topics that family medicine docs are facing. So if we could just maybe take a look at the required rotations and the length of each rotation. Maybe incorporate some of the new challenges coming up in family medicine." *~Resident*

- "More curriculum flexibility, more chances to learn that would be applicable to your practice. Like I will be doing OB/Gyn when I graduate but I'm not going to be in the ICU. So maybe I could spend more time on L&D and less time in the critical care unit." *~Resident*

- "I think a lot of times we do a lot of community rotations, so we go out and do FQHC, underserved care, things like that. We might be in those setting a little bit more often but going out and being in a private practice, I definitely would want to rotate many private practices for anything. I think one, if you're a person interested in going out and having your own clinic, that could be helpful, learning how to manage that. I think also, just even medicine, when you're working with Medicare and Medicaid, you don't learn a lot of medicines because you're like, all right, my patients can't afford this, this is not going to be covered by that so I'm not even learning, not even thinking about it. But then if I were to go out on my own I feel like I might not be using the newest meds or whatever or some of the meds my patients might come to me with, I might not even know what they're about because they have private insurance that doesn't cover that. So, I think maybe exposure to that could be helpful as well. Family medicine has a wide variety of settings, like direct primary care which not everybody's into but I think the option of rotating it, or concierge medicine or something like that. We don't really rotate in all those settings but they're out there so if somebody were to get into it, it might be a big transition from residency to that." *~Resident*

- "I think more programs should have tracks. I know ours does. I know a lot are moving towards that, but maybe more programs should have tracks instead kind of forcing OB on you or if you're interested in hospital medicine, doing more inpatient than people who really aren't." *~Resident*

What new curricula new skills should be present in resident training?
✓ Residents were interested in learning more about the variety of payment models, leadership skills needed in the workplace as an employed physician working in a large system, technology, and working as a team such as social worker, care manager, psychologist, etc.

Payment Models and healthcare delivery

- "I think one of the big areas I feel like my training is lacking is better understanding of the various payment models and structures for providing care after residency. And then a lot of the administrative type things like prior auths and what not that we were talking about. Just kind of some of those necessary evils that we don't really get training in that are going to be a reality very soon and we'll have to deal with. *~Resident*"

- "That's exactly what I was going to say, what she was saying. Just working in the county system, we have, I guess, one very specific way that we deliver healthcare and it would be really interesting to see what other models of healthcare delivery are out there, just to read profiles for other practicing physicians --." *~Resident*

- "There could probably be more education on the payer model and stuff like that for sure. I went and sought that out, but I don't know about my colleagues. If they don't do the health policy elective, do they really know it? Even still, I don't feel like I necessarily know it, I did that elective." *~Resident*

- "I don't think there's nearly enough education for us in the variety of payment modes and I think that would be really important because people are coming from so many different backgrounds that different types of insurance and whether or not they even have insurance, I think is something that really should be taught and just explained because it's very complex and personally, I don't know much about how that works." *~Resident*

- "I think it's the growth of healthcare delivery, the different methods of healthcare delivery and all of the places in which your patients seek care. So, I think understanding that our patients seek care from a lot of different areas and the difference between healthcare and policy and that key differentiation helps set the groundwork us to understand sort of the impact of the social determinants and the lifestyle stuff." *~Resident*

Telemedicine

- "I think telemedicine going to be a big part of our careers going forward, not only because of COVID, just because how technology is moving so fast and its incorporation into healthcare so I think more education along that line, more training and of course, developing more research we can use in technology related to healthcare I think would be very helpful too, from a family medicine perspective." *~Resident*

- "I think things like telehealth. Up until Covid we didn't do any telehealth at all in our residency and we've really just kind of gotten that kicked off here recently. But I think it will be hard for patients to go back to not having telehealth options, so I think that will be more and more important to get training in telehealth and video health and to other non-traditional ways of reaching patients to be included in residency training going forward." *~Resident*

Team-based approach working in an in-patient setting

- "And I would say the team-based thing, most of our training is by doing a team-based approach more so on the inpatient side, I guess. But we don't necessarily have a lot of formal lectures or workshops necessarily on how to optimize our team-based approach. So that might be something that … I still think that learning by doing is the best in that regard, but having some sort of *~Resident*

- "I am looking forward with working in my community on social detriments of health issue on behalf of my patients, but I am interested on closing the loop with the other players on the team. So, how to work with the social workers, etc." *~Resident*

The development of leadership skills

- "I will most likely go work for a large health system, but I am very nervous about having my voice heard so I can part of the decision-making being made on my behalf. So, any training on leadership and working the politics of the large system would be greatly appreciated." *~Resident*

- "I think if residents are able to learn the process of how it's used, like figure out a better health system and engage in that system, I think that's where the leadership development and the advocacy piece can play a big role. You don't have to be involved with health policy necessarily to be an advocate. You can be an advocate within the exam room too." *~Resident*

B3. HOW SHOULD WE TEACH?

Audience: Medical students and no background papers

What new teaching technologies will improve outcomes in education?
✓ Medical students indicated the new technology tools they believe will improve outcomes in education are more interactive clinical/medical case scenarios, telemedicine, artificial intelligence, and personalized learning resources.

Interactive clinical and medical case scenarios

- "So just thinking about some of the potential of these interactive case scenarios in preparing students for their clinical years, I can see that being really super helpful." *~Medical Student*

- "I'll be brief. I was just going to agree with what she had said. We also used Case X. But we used a couple of interactive formats where they're similar to Case X in that they give a presentation then you slowly move through the workup. But I would definitely say that many of what we used throughout my third year were outdated and Case X was certainly the most up-to-date, the most user-friendly and it's certainly more clinically oriented. It wasn't just trying to get you the right answer on the boards. It was actually giving you information that was going to be useful in real life. Not that the boards information is not, but that was definitely its focus. And I thought that was really superior, so I wanted to agree with that." *~Medical Student*

Virtual reality and artificial intelligence

- "The closest that I got to any virtual reality type learning as also anatomy. It seems like a far more primitive version of what you were describing, called Essentials of Anatomy. It was just an app for the computer but similarly intended. You could zoom in, you could move around. Everything was anatomically correct. And you could go deeper layers or more superficial and it would give you information on any piece that you highlighted or wanted to see. And for our program, we were with precept anatomy to kind of shorten the time spent in the anatomy lab. And that left some people, like myself, kind of wanting more. And I found that application to be super helpful. And it doesn't sound like it was anything as sophisticated as what you just described, so I could really see the utility in it potentially, I guess." *~Medical Student*

- "I haven't seen this in practice, but I could see the value of some virtual reality kind of as a supplement. We do in person simulation, but I feel like it's kind of never enough simulation time. So, if there was something you could do at home or in a virtual space, that would be awesome." *~Medical Student*

Telemedicine

- "Since a lot of things have moved to like telemedicine and there are platforms for that, I think it would be helpful, and maybe this would happen eventually, or other forms of modules or trials … But kind of have the differential virtual platforms for telemedicine and how those are being utilized more now and will continue to be utilized for the future. So those resources would be useful." *~Medical Student*

- "And I think somebody mentioned earlier the idea of more telemedicine integration. I'm doing my -- right now and having advanced, in-service calls, they're like over an iPad or over the phone, it's terrifying, it's like impossible, it sucks. And being exposed to that, I think that's going to continue to be a large part of the practice going forward, not just now in Covid times. So I kind of wish that I had a little more practice of how to do an evaluation when I can't physically see the person. So I'm really weak in that." *~Medical Student*

- "I think that telemedicine is going to be part of the future of family medicine, whether you want to be at it or not. And we had a four-week telemedicine elective during the Covid disaster. And someone said you don't get as good as your physical exam. Well, there's a lot of ways to do a really good physical exam over telemed. You just have to get creative. So being forced to do it was really helpful. But, also, it makes you better at taking a history. Like if you take a lousy history, if you just rely on these other things, then telemedicine is going to show that. So just to kind of be a devil's advocate, I think telemed does actually have a place and will be really helpful. And I think in training it should absolutely be part of training at this time, whether it ends up being in residency. But even I did a sub out where I did a lot of telemed and I was much more competent than the residents doing the telemed because we had that elective and we practiced." *~Medical Student*

Personalized Learning Platform

- "I like the idea of a tool that will test my knowledge gaps via a personalized learning tool and then it recommend additional resources on that particular topic that I am weak. I see using an interactive app that will know my weaknesses based on my answers to several questions. Something similar to Osmosis." *~Medical Student*

How should competencies be best assessed?
✓ Several echoed the following medical student's sentiment that current competencies are too subjective and should be standardized.

- "I think measuring competencies is something that's pretty different across all med schools. I would be curious how other medical schools do this but I think at my medical school, we're given a list of objectives for each rotation that are designed by whoever is the physician directing that rotation. I find that sometimes they can be pretty subjective. I'm curious if it might be beneficial to have more national guidelines for all medical schools for deciding -- competency in family medicine, for instance, just because the rotations also vary widely. For instance, I had really good, robust family medicine rotations but I'm sure other students might not have had the chance of having good family medicine rotations. I think it would be good to have more standardized ways of doing that." *~Medical Student*

What attracts you to family medicine?
✓ The breadth of family medicine was the primary theme of why medical students would be interested in matching into family medicine. ✓ Building relationships with their patients was close behind. ✓ Some of the barriers included the following: not being able to practice full scope after graduation, the perceived threat of NPs and PAs, and family physician's salary not as competitive as other specialties.

Breadth of opportunities intrigues medical students

- "What I really love about family medicine, the cat's meow, the bee's knees, you get to do pretty much everything. There's so much flexibility, you're not limited, there's no glass ceiling. You can work with children, with adults, women's health, absolutely anything. For me I really like that because in 10, 20 years, I'm not going to be limited to doing just one particular thing. You can do primary care, rural care, all sorts of beautiful things and is what will attract me, what does attract me to family medicine." *~Medical Student*

- "I definitely agree and I feel the same way about having options to pursue different fields. I also love that family medicine doctors all seem focused on social justice and health equity and I found that to be a common theme among family physicians that I've worked with, really caring about the factors that impact health and trying to make healthcare more equitable as a whole." *~Medical Student*

- "And family medicine as well is choice for me. But I have all these classmates saying, oh, I'm going to do family medicine because they want to do a fellowship. What's really hard is that they just did sports medicine or they're just realizing what's possible from family medicine. And I'm at a new medical school, I was part of the group that formed a family medicine group. And these are people that would never have been part of anything. They've never done anything with family medicine. And now they're like, well, family medicine. And I think it's really just because they didn't know. So I think that's a little bit of a weakness in sort of family medicine, if you will, is what's possible. We always say broad patient panel. We say you can see cradle to grave, whatever. But some people don't care about that. They're like, oh, sports med, that's for me." *~Medical Student*

Building relationships with patients

- "I think something that is really cool about family med is how great relationships you can develop with your patients. Like I haven't had my family medicine rotation yet, but one of the people who I shadowed before med school was a family medicine physician and it's just so cool seeing her go into a room and she knows the whole family. She sees the kids, she sees the parents. Just really being able to build really good relationships with patients. And I think there's so much opportunity for advocacy too. The AAFP and just in general I feel like it's a really good specialty for patient advocacy and things like that. And just the variety too. I'm kind of going through and I'm like I really like psych, I liked OB. And it's like you go into family, you're doing all of that, which there's really no other specialty that lets you do that." *~Medical Student*

Barrier – not doing full scope medicine

- "One of the things that makes me a little leery about matching with family medicine is, I guess it's specific to the region that I'm in, I'm in the New York City area and I find that here and in other large cities, family medicine doctors don't really get the opportunity to do the full scope of family medicine and that's something that's in more rural areas and if a doctor doesn't necessarily want to live there, personally that's not my preference, it's a little sad because I feel like I will get a really good training in family medicine and then it'll the location will determine how I practice." *~Medical Student*

Barrier – family physicians will no longer be needed because of NPs and PAs

- "I have one other point. I don't really have much of an opinion on this, but whenever I talk to people about how I'm interested in primary care, a lot of doctors will say, or residents will bring up, like nurse practitioners are gaining independent practice, potentially taking future job openings. So that is something that I feel like I'm hearing a lot more about. A lot of people are like go do surgery because you'll never lose that job position." *~Medical Student*

Barrier – doesn't pay enough

- "The biggest one I always hear is the just financial barrier because people get significant loans and specialize and do more lucrative careers. Not that you can't make great money in family medicine, but that's one that comes up the most." *~Medical Student*

B4. HOW CAN RESIDENCY SUPPORT GRADUATES' ABILITY TO SHIFT PRACTICE AND POPULATIONS OVER TIME?

Audience: Residents and family physicians and no background papers

How do we prepare future physicians to respond to the following during their careers? • ***Patient populations*** • ***Practice settings*** • ***Trends in healthcare***
✓ Many echoed the fact that family physicians are trained to be nimble and flexible. This is the backbone of family medicine being prepared to work across many patient populations, working in a variety of practice settings and keeping up on the trends in healthcare. ✓ Several cited being able to continue their passion for learning during their career will assist them in acquiring new clinical skills to provide best care during the shift of their patient population or a career change.

Family physicians are trained to be prepared for change

- "Comprehensiveness of our training gives us more options to be able to change with the system." *~Family physician*

- "I really like the mention of telling students be flexible, be ready for change. And then I would tack on, like she said too, the bedrock of what we do and why we do this is to care for other human beings. And we really have it pretty good compared to other people in different jobs, and with the Covid. But teaching residents, I think the idea of giving residents more choices based on where they know they want to be when they're done, that's got to happen in the future." *~Family physician*

- "That is what I love about family medicine is that we're prepared to do anything. Look what happened during COVID, who did hospitals call on? They looked to family physicians because they knew we could quickly put on another hat and learn quickly in a new environment." *~Family physician*

- "I think if we have this ability to train and retrain ourselves through these recognized programs that we can have established physicians who want to go back and do O.B.. We have retraining programs for additional certification like, let's say, in occupational medicine or obesity medicine, that you can do after you've been in your career for a number of years." *~Family physician*

- "That is why I went into family medicine because it is never boring, and I can always take CME courses to improve my skill where there is a gap to meet the needs of my patients." *~Resident*

B5. WHAT IS THE RIGHT BALANCE BETWEEN INNOVATION AND STANDARDIZATION?

Audience: Commission on Education and RPS Consultants and background Paper #7

How do we ensure that everything graduating residents have the necessary knowledge and skills to function as a fully competent family physician while also encouraging innovation in residency education?

How much time in residency should be flexible to allow for individualized enhanced innovative experiences?

- ✓ Most felt there were too many restrictions to be innovative while a few wanted more standardized requirements.
- ✓ However, there was a common theme on the lack of standardized requirements for procedures required for each graduate.
- ✓ Several voiced the value for additional innovation because each program has different needs depending on the location and the faculty experience to teach the requirement/skill set.

- "I think this is ultimately the biggest question that exists. I think putting the numbers on everything really restricts the ability to innovate. I think all of us have very different experiences in very different settings and I fully advocate getting rid of numbers and really putting in more experiences in place. Whether that's a certain number of locks in something or whether that's just an experience, I would favor that over counting 750 hospital touches and all of the numbers we have to keep track of. I think that becomes exceedingly difficult in certain settings when the

system doesn't do that for you and the individual residents are responsible for that. I think it really should be defined more as competence in an area and however we want to define that, then we need to do that with different experiences." *~RPS Consultant Member*

- "I think one of the big difficulties is that we are somewhat restricted by the numbers as well. Each of our programs have unique advantages that we can offer, basically to our residents but the requirements that they have, sometimes are so restrictive that they're hard to implement exactly what we can offer." *~RPS Consultant Member*

- "I think that it becomes difficult to innovative if we're spending all of our time trying to meet standards and so the movement is an inverse relationship between standardization and innovation. And the more standards we have in place, in other words the more things we have to follow in our seventy pages of RRC guidelines, the less time there is for innovation. So I think that the inverse standards might start at higher levels of innovation. But I'm not necessarily --for that. That's just my observation.*" ~Commission on Education Member*

- "I think as long as residents are part of it and it's not being told this is what we're going to do. There's just so much change going on in residency. And the Clinic First model is great but it is happening from a lot of --. It creates that comprehensive mindset, but I think until our resident's kind of get used to that, it probably feels like a lot of change. But I think if they're part of innovation, they really actually embrace it. Then they learn how to innovate themselves down the road. So it's a great skill set to develop." *~Commission on Education Member*

- "This may be a very niche comment and I apologize if it is. I am maybe alarmed is not a strong enough word – but I am shocked by the lack of ability of residents to do office musculoskeletal procedures when they get out of residency. I don't know what's happened. I was trained to do that. This is going to be even more important as we start to incorporate more office-based ultrasound. you talk about technologies, that's just an example of where that's going to go. So, I know that there is variableness, as we sit here today, about how people have incorporated office-based ultrasound into the clinical world specifically in an outpatient environment. But I think that's a trend that's going to continue to accelerate, so somehow or another we've got to weave that into the educational process where people are comfortable with that sort of thing. Frankly, family doctors don't need to refer injections to orthopedic surgeons." *~Commission on Education Member*

B6. HOW CAN WE CAN IMPROVE THE SOCIAL ACCOUNTABLITY OF GRADUATE MEDICAL EDUCATION?

Audience: RPS Consultants and background papers #1 & #8

How can we improve the social accountability of graduate medical education? ***How effective are current mechanisms of continuous quality improvement for residencies?***
✓ Even though most of the participants felt there is definitely a need for improvement in the area of social accountability but there needs to be some boundaries and the training needs evidenced-based. ✓ Many felt the effectiveness of quality improvement projects really depend on the interest level of the residents completing QI projects.

Social accountability

- "Advocacy training directed toward social justice in medical care. This is a tough one to put appropriate boundaries around. There is a need for broad appreciation of the evidence around social determinants of health, but it gets more complex when it comes to what specific elements are an expected part of professional advocacy versus what elements are part of good citizenship and democratic participation." ~ *RPS Consultant*

- "There needs to be some discernment about how, if at all, the ACGME can protect programs, faculty, and residents from retribution if their social justice advocacy puts them into direct conflict with their institutional sponsor." ~ *RPS Consultant*

- "I wish there was more evidence-based training to support it, especially on the topic of implicit bias training. Most of my residents are very passionate about health equity topics and social determinant of health but as I mentioned the outcomes are a mixed bag." ~ *RPS Consultant*

Quality improvement

- "More vigorous training in safety and quality Improvement. Graduates need a sophisticated understanding of population-based data analysis and clinical decision making. They should be able to perform as team leaders for quality improvement initiatives in team practice and integrated system environments." ~ *RPS Consultant*

- "We do some QI work as part of our residency program, to graduate. That sort of teaches them to kind of push the envelope and not just do things the way they've been done before. Work on things that are bothering you. I think it's a mixed bag. For some, the enjoy QI work and so it's fun sort of doing it but for someone who has no interest in doing QI work or that sort of research, it's sort of painful to have that shoved down their throats. I think it's person to person." ~ *RPS Consultant*