Family medicine organization convening focus group: Society of Teachers of Family Medicine

Participants (type and name): Associate Deans

	What questions did your focus group address and discuss?	**What themes were developed in the discussion?**	**Any foundational or critical components in the themes?**
1	What does society need from the family physician of the future?	The needs vary by setting. Need to very clearly differentiate what is different between us and other primary care providers (NPs/PAs). Need to train FPs to be systems thinkers: how to have 1:1 relationship within whatever context you're in and what the roles of different professionals should play within systems. The training should be about how to be flexible to meet needs of communities, rather than so much on broad scope medical knowledge. Knowing how to treat the most common problems is not necessarily what the emphasis of training should be. Others can do that based on algorithms. The uncommon conditions are what is key. And breadth. A shift over time has been managing populations. Need more in curriculum about this and possibly less on things like inpatient pediatrics.	FPs need to be trained to deliver care in any place/setting in the world – more about building the skills to meet the needs of communities than about broad-scope medical knowledge. The essential role of family physicians is helping patients make decisions based on what the FP knows about them and about their conditions and about medicine. This is the part of practice that doesn't vary based on geography. Perhaps we need to stop calling ourselves primary care providers.
2	The four C's (first contact care, continuity, comprehensiveness, coordination of care) were core in the development of family medicine. Should the 4 C's be updated for the 21rst century? If so, how?	All are very relevant for FM teams. Coordination definition may have changed. There's an administrative role, like getting prior authorizations and scheduling; that doesn't have to be done by a physician. This is different than figuring out what the patient issues are and what needs to be done and what referrals need to be made. The family doctor is who you go to when you have multiple things happening and	Coordination needs to be looked at, knowing that there are both administrative components and decision-making components. Other possible "C's" include community and communication.

		you need someone who understands you to help you figure out what to do. Communication may be a 5th C. Especially important in the shift to telehealth.	
3	What does first contact care and access to care mean in an age of increasing non 'face-to-face' encounters (such as telehealth)?	This is an idea that may need revising. FPs don't necessarily need to claim ownership for all first contact care. Some people enter care with simple needs and stay there. May not need FPs. First contact can mean more than one thing. This goes back to the need to train FPs how to work in and create systems where patients can communicate with who they need to.	FPs don't necessarily need to claim ownership for all first contact care.
4	How should telehealth and urgent care fit into continuity care?	Need to teach medical students and residents to interact with patients in an age where patients don't come into an office. You lose all of the cues. First contact has changed and our systems are all built around first contact in the office.	
5	How will we train physicians to work in and with communities to address disparities and the social drivers of health?	Advocacy training should be a part of residency, as should expectations for resident involvement in communities. Not just in rural areas. Communities recognize and respect knowledge of FPs. We saw this with COVID.	Community engagement is a responsibility of FPs. This skillset should be a part of FM training.
6	How can we improve the social accountability of graduate medical education?	We're the most socially accountable specialty in the US. We have the data to support this. We don't need to put more pressure on FM residency programs to do more or better. The big issue is that we're wanting to move GME funding from those who have it. Need to get more FPs in leadership positions – across the board – in order to get a rational distribution of GME slots. It is not a FM problem that GME is not meeting the needs of society. Need those making the decisions for the country to act. THC program is only rational program in the country. We need to ask Medicare and Medicaid to follow that lead. GME funding affects training and what populations are served. There needs to be more transparency in how public funds are used.	Advocacy is important.

In 1-2 sentences, please summarize your focus groups conclusions, if any.

Family physicians should be trained to be personal physicians and also physicians for communities. Training should be less about the basics of broad scope-of-practice and more about how to think about how primary care teams deliver care. Physicians need to come out of residency with a focus on life-long learning, with the ability to flex and enhance skills as needed to address the changing needs of communities. We need to explicitly define the difference between family physicians and other primary care providers.