Quo Vadis, Family Practice Residency Programs?

William L. Stewart, M.D.

Springfield, Illinois

I would like to express some of my growing concerns relative to the mechanism for approval of family practice residency training programs. I perceive a slow but ever-increasing rigidity on the part of the Residency Review Committee with respect to approval of new programs. My concern is that we are not quite ready for such rigidity, and, indeed, maybe never should become as inflexible as some of the other residency review committees. Many of the residencies in internal medicine, for example, are carbon copies of one another. However, by its very nature, Family Practice varies from location to location and is certainly vastly different in the various sections of the country. I see a golden opportunity that may be missed for us to allow the development of innovative programs. Residency review committees for the other specialties do not allow for this, and this is, in my opinion, a mistake that we should not repeat. By this, I am not advocating a lessening of control over the educational quality of the program. What I am advocating is that we monitor the quality of the product instead of prescribing a rather rigid sequence of experiences for each program. Programs should have sufficient degrees of flexibility to allow them to capitalize on local strengths and minimize weakness without being penalized. We need to develop rapidly some objective measure of the resident's acquisition of behavioral skills, psychomotor skills, and cognitive knowledge. This should be developed on a national basis and administered to all residents for a modest fee. This would give us a mechanism by which we could objectively measure the educational content of a program and insure that the end product will meet certain predetermined criteria. It is only in this manner that we will be able to objectively assess the success or failure of an innovative program.

A great deal of emphasis has been placed by the Residency Review Committee on continuity of care, and rightly so. However, in the opinion of some of us, the Committee has occasionally gone overboard on this matter. Although the Committee will approve a program that puts the third-year resident in a community practice for a month or two, it always does so with a derogatory remark with respect to continuity of care. This criticism seems unrealistic to many of us, particularly in view of the fact that the resident will be leaving the program shortly anyway. Furthermore, most of our residents plan to enter a partnership or group practice in which complete continuity of care is an impossibility during vacations and postgraduate educational experiences. The benefits to the resident of such an experience in a community practice seems to far outweigh the disadvantages. The emphasis on continuity of care also seems contradictory when the Residency Review Committee will approve programs in which the first-year resident spends one half-day per week in the Family Practice Center, the second-year resident spends two half-days, and the third-year resident spends three half-days; in such programs the resident is only spending 20 percent of his entire three years providing care for his families. In actual practice, he will spend 80 to 90 percent of his time in this activity. Continuity of care is much greater if he spends more of his time in the Family Practice Center, even at the expense of a month or two in a community practice. After all, is not the purpose of the residency to make the resident practice ready?

There seem to be different criteria applied to the approval of residencies in university hospitals compared to community hospitals. I recognize the necessity of developing residency training programs in hospitals where the medical students can see and experience family practice. However, some of our weakest programs are in university hospitals where there are insufficient beds, and the family practice resident is treated as a second-class citizen at best.

It is becoming increasingly difficult to obtain approval of a program in a community hospital unless there are full or part-time heads of all of the clinical departments. Has it been conclusively proved that this results in a better educational program? Was there any input from program directors in this apparent decision? Will this not exclude many fine community hospitals from developing a residency program in the future? These are questions that it seems to me need to be answered prior to the development and implementation of such policies.

It is now very difficult to obtain approval of a program with less than nine months of internal medicine, and there is some consideration by the Residency Review Committee to increase this to one year. Again, has this been proved the best way to train family practice residents? Is one year on a tertiary medical service in a university hospital valid training for a family practice resident? We need answers to these questions and many more.

Three things are urgently needed. First, we need a national external examination to be administered to every family practice resident on an annual basis. Second, the directors of programs should have much more input with respect to policy decisions of the Residency Review Committee. Thirdly, we need a much better assessment of already existing programs than is provided in many instances by the site review by the AMA. The Academy is already in the process of developing an answer to this latter need. We must address ourselves to the first two needs. If this is not done quickly, I am afraid that we will lose virtually all degrees of flexibility in the near future to the detriment of our programs and their continued improvement. JFP

From the Department of Family Practice, Southern Illinois University, School of Medicine, Springfield, Illinois. Requests for reprints should be addressed to Dr. William L. Stewart, Department of Family Practice, Southern Illinois University, School of Medicine, Post Office Box 3926, Springfield, Illinois, 62708.