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Family Medicine Predoctoral Education: 30-something

Howard K. Rabinowitz, MD

The specialty of family medicine is now more than 30 years old. Fitting for its stage of life, family medicine predoctoral education has achieved appropriate maturity and parity with other core clinical departments and has assumed its role and responsibility in medical education within the academic health center. Of course, this wasn't always true. When I first joined the faculty of our department of family medicine in 1976, I was asked to direct the required third-year clerkship and fourth-year preceptorship. At that time, there were few other schools with a required junior clerkship and thus few resources available or colleagues to learn from. In fact, even several years later—in 1980—only 32 US medical schools had any required family medicine clinical courses. But, this increased to 70 schools with a required course by 1988, with 36 of those schools requiring third-year clerkships. By 1999, more than 100 medical schools had a required family medicine clinical rotation, and more than half of all schools had a required third-year clerkship.[1-3]

Family medicine rotations have not only increased in number over the past 3 decades—they have also played an important role in advancing the overall educational experience for medical students. In fact, in many schools, family medicine now provides the largest block of ambulatory training for students, something that was missing from medical education in the past.[4-6] Family medicine has also been at the forefront of moving medical education out of the tertiary care center and into the community, allowing students to learn in the same setting in which the vast majority of medical care actually occurs.

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From the Department of Family and Community Medicine, Thomas Jefferson University.

Developing Curricula for Family Medicine Education

When I began as a clerkship director, our basic structure was simple: to teach third-year students in our university-based family practice center and in our affiliated residency programs and teach fourth-year students in community-based family practice preceptorships. Our curriculum was organized around the patients we saw and was concentrated on what we did. While our focus was exactly where it belonged, there was not yet a structured curriculum that had been articulated or could be shared with others.

Four years later, I attended one of six regional conferences that took place as part of a Society of Teachers of Family Medicine (STFM) Task Force on Predoctoral Education project to develop a monograph describing family medicine predoctoral educational activities. The project, funded by the Family Health Foundation of America and led by Terry Kane, MD, involved more than 100 family medicine educators and resulted in the 1981 manuscript, "Predoctoral Education in Family Medicine."[7] Nine years later, David Swee, MD, led another project to update and supplement the prior monograph. I had the opportunity to serve on the editorial board of that second project, and the resulting publication was titled "Teaching Family Medicine in Medical School: A Companion to 'Predoctoral Education in Family Medicine.'"[8] Around that time, Kent Sheets, PhD, also led an STFM Working Committee—funded by the Health Resources and Services Administration (HRSA)—to develop "Curricular Guidelines for a Third-year Family Medicine Clerkship."[9]

The Family Medicine Curriculum Resource Project

Building upon this history, and after curricula developed through HRSA-funded projects in pediatrics and internal medicine were shown to have enjoyed widespread use, the Family Medicine Curriculum Resource (FMCR) Project was born in 2000. This HRSA-funded project, awarded through a contract to STFM, was not only the newest curricular resource in family medicine but also the most refined. While I have not had any formal relationship with this project, I have followed its progress and have had the opportunity to use its Web-based resources.

The seven articles in this issue of *Family Medicine* comprehensively

address the process and content of the FMCR Project. They are written by the leaders of the project, individuals who are also national leaders in family medicine education. As a group, these papers provide a broad history of the project, the process and decisions underlying the program's framework, and an overall perspective of the various predoctoral curricular resources that were produced. Specifically, the seven papers address (1) the program's overview, (2) its structural framework, (3) competencies that are prerequisites for the family medicine third-year clerkship, (4) the family medicine clerkship, (5) the fourth-year medical school curriculum, (6) faculty development, and (7) a discussion of future issues.

While these papers are well written and informative, they in no way capture the entirety of this comprehensive project. Because of this, one needs to not only read these papers but also to log on to the FMCR Web site (www.stfm.org/curricular/index.htm) to experience the totality of the resources that have been developed. You can't really appreciate the richness of the FMCR Project without visiting the project Web site.

In developing the FMCR resources, the leaders of the project made a number of important decisions. First, they showed how the project grew from the past history of family medicine education and then integrated the outcomes of the project with the changes taking place within the discipline of family medicine through the Future of Family Medicine initiative. They also embedded their work into the broader context of overall medical education, including work from the Institute of Medicine and the Association of American Medical Colleges. The inclusion of educators from general internal medicine and general pediatrics—stimulated by HRSA and expanded by the project leaders—represents an important decision in this project. Having leaders from the three primary care disciplines working together to develop the basic interdisciplinary requirements necessary for all students prior to starting their core clinical training interweaves family medicine education within the overall framework of primary care education. Finally, the leaders of this project wisely decided to frame their curricular structure around the six Accreditation Council for Graduate Medical Education (ACGME) competencies that are guiding graduate medical education (GME), connecting predoctoral training within the same structure as GME, thereby reinforcing the continuum of medical education.

Rather than prescribe any specific curricula, the FMCR Project instead provides resources for educators to use within their own medical school. Each of the four specific components of the project—the preclinical, third-year clerkship, senior curriculum, and special projects—is cross-referenced by the ACGME competencies and includes specific goals and objectives, recommended resources, implementation strategies, evaluation strategies, faculty development recommendations, and comments on resource challenges. For the family medicine clerkship, each of the ACGME competencies is organized around core family medicine principles, and the three family medicine themes of acute and chronic illness, prevention and wellness, and community and population medicine. Resources have also been developed around 29 core family medicine topics (eg, chest pain, cultural competence, rural), as well as eight special topics (eg, informatics, oral health, geriatrics). Specific Web-based and print resources are also listed, as is information on faculty development.

Challenges to Medical Education

Despite the substantial achievements of the FMCR Project, medical education in general and family medicine education specifically are facing new challenges. As Ludmerer has described in his book, *Time to Heal,*[10] teaching requires time. Today, however, education is often seen merely as a byproduct of patient care and its resultant income generation, rather than what it should be—the primary mission of medical schools. Despite the fact that medical education is paid for with rising medical school tuition dollars, faculty teaching time seems to be decreasing. Perhaps medical education should take a lesson from the clinical reimbursement strategies that are being initiated and develop a "pay-for-(educational) performance" strategy regarding teaching. That is, faculty who effectively teach should specifically be paid to do so but only for documented outcomes showing that their students meet defined educational goals.

Another challenge of enormous importance to family medicine education is the relationship between family medicine and the other primary care disciplines of general internal medicine and general pediatrics. While HRSA and the FMCR leaders had the wisdom to have the three primary care disciplines work together on this project, the future of primary care and primary care education will require much more collaboration. This is because most of the critical decisions regarding primary care will be resolved, for better or worse, in a political arena—within organized medicine, legislatively, and even within curriculum committees. Having three primary care specialties, each with their own agendas and self-interested voices, will reinforce that each will be ignored—while their combined force would represent a much larger number of physicians

and thus collectively speak with a much more powerful voice.

Funding for Education

I would be remiss if I did not make special mention of the critical importance of HRSA to family medicine and medical education over the past few decades. The recent budget cuts in Title VII programs and the enormous effects of those cuts on family medicine education only highlight their significance. But, while all understand the importance of HRSA's financial support, many don't fully appreciate the role of HRSA's leadership and guidance. One has only to look at the projects mentioned above, like the FMCR Project and countless others at most of our institutions, that were supported by HRSA, and it is possible to understand the major role played by HRSA in the development of primary care education—and the role it will no longer play should funding for Title VII programs become unavailable.

Conclusions

So family medicine education has now reached its 30s with a proud heritage, having made enormous progress in teaching medical students. But it is also doing so at a challenging time for family medicine and for medical education in general. While the number of US medical students entering family medicine has decreased in recent years, it still represents one of the largest of all medical specialties. In addition, family medicine educators continue to play an important role in teaching all medical students, not only those entering the specialty.

But, to train future physicians to provide the highest quality care to patients, medical student education, including family medicine education, will require significant resources and time to teach. This will also be necessary if faculty are to take full advantage of the FMCR Project. Educational research and evaluation will also be critical to measure the outcomes and impact of this project on family medicine education.

Personally, I believe that the FMCR is an important project for medical education and a wonderful resource for medical educators. I hope that family medicine educators will read these papers and also make good use of the myriad of excellent resources available at the FMCR project Web site. I wish it had been available 30 years ago!

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