STARFIELD SUMMIT

...where primary care research inspires policy and practice

Social Accountability of Graduate Medical Education

Why this is important (brief description):

Public financing of graduate medical education (GME) in the United States has grown from $100 million to $16 billion per year since its inception in 1965, and hospitals were given the responsibility of training physicians based on the needs of their communities. Thus, many argue that institutions receiving GME funding should be more socially accountable for their outcomes. Family Medicine plays a crucial role in meeting the health needs of the population and should aim to also be accountable for training outcomes. Many communities have difficulty sustaining a stable primary care workforce and rural areas have seen a steady erosion. Communities also have different needs and training should prepare family physicians to be capable of meeting those needs to include broader scope of care (OB, inpatient, procedures) or partnership

What We Think We Know (Bulleted evidence + Seminal references): there are no references here

- GME Outcomes such as specialty choice and geographic location are measurable using administrative data sources
- Most family physicians work within 100 miles of where they trained. 54.8% of FM physicians practice within 100 miles of their residency training site, 46% within 50 miles, 19% within five miles of their residency training site.
- Family physicians with exposure to rural and underserved sites in residency are more likely to work in rural and underserved settings
- Graduates from programs located in rural areas and programs with fewer other subspecialty training programs are more likely to work in rural settings.
- Teaching Health Center graduate are more likely to work in safety net settings
- Graduates of the P4 initiative reported high rates of performing vaginal deliveries, adult inpatient care and nursing home care and those exposed to lengthened training were more likely to include adult hospital care, adult ICU care and newborn resuscitation.
- There are modifiable recruitment and training strategies that modify training outcomes
  (See 2019 AcMed Phillips Bartlett review)

Questions for Group Consideration at the Starfield Summit:

- Do the outcomes associated with increased length of training meet the medical needs of our population? (i.e Is there a need for more adult hospital care, adult ICU care and newborn resuscitation providers). Does this need differ by location of residency? Population served?
- Should there be a once sized fits all approach for residency curriculum/length of training given that different communities have different needs?
- We know that most family physicians work near their training site. So, for residencies not located in or near medically underserved areas, what curricular changes should be made to give residents exposure to these communities?
- Is it simply exposure or broader curricular differences that contribute to the outcomes seen in rural training tracks and Teaching Health Center graduates?
- What are the most feasible and meaningful outcomes to measure?