



Educating Family Physicians

AAFP Government Relations

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“Family Medicine symbolizes a commitment to a style of practice that is focused on the patient, the family and the community, rather than on the disease. Family Medicine has found a niche at the interface of scientific medicine and public service.”

— John W. Saultz, Textbook of Family Medicine

What is Family Medicine?

Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity.

Quality healthcare in family medicine is the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients' families, personal values, and beliefs. Because of their extensive training, family physicians are the only specialists qualified to treat most ailments and provide comprehensive health care for people of all ages - from newborns to seniors.

How are Family Physicians Educated?

A Family Physician's education is lengthy and involves three levels of education: undergraduate, medical school and graduate medical. The process begins with four years at a college or university to earn a bachelor's degree, usually with a strong emphasis on basic sciences. This is followed by four additional years of education at a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association's Commission on Osteopathic College Accreditation (AOA COCA). After graduating medical school, students earn their doctor of medicine (MD) or doctor of osteopathy (DO) degrees. However, they must complete additional residency training program *before* they may practice on their own as a physician.

Through a national matching program, newly graduated MD's and DO's enter into a residency program that is usually three years or more of professional training under the supervision of senior physician educators. As part of a family medicine residency, new family physicians participate in integrated inpatient and outpatient learning and receive training in six major medical areas:

- pediatrics,
- obstetrics and gynecology,
- internal medicine,
- psychiatry and neurology,
- surgery, and
- community medicine.

They also receive instruction in many other areas including geriatrics, emergency medicine, ophthalmology, radiology, orthopedics, otolaryngology and urology.

After completing their education, a family physician must obtain a license to practice medicine from the state or territory in which they plan to practice. A permanent license is awarded in most states after completion of a series of exams and a residency training program in the physicians specialty.

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What is the difference between a medical school and a residency?

The Association of American Medical Colleges defines a medical school as “any school that grants degrees of MD and is accredited by the LCME, but does not include osteopathic medical schools,” which are accredited by the AOA COCA. As of July 2006, there were 125 U.S. and 17 Canadian accredited medical schools.

A residency program, though, as describe by the American Medical Association, is “...a program that is three to seven years or more of professional training under the supervision of senior physician educators.”

For family physicians, as well as pediatricians and general internists, residency training lasts for three years. Additional years of residency training are required if the physician wishes to acquire a subspecialty such as sports medicine, for example.

How much does it cost to build and sustain a medical school versus a residency?

Recent estimates place the annual cost of medical school in the range of \$67,000 to \$80,000 per student, of which state appropriations cover anywhere from 50 to 90 percent of the cost. Each new medical school carries an additional operational cost. For example, the total projected capital cost of the proposed University of California Riverside medical school is \$496 million; a fifteen-year estimate of total operating costs stands at \$192.5 million. The proposal for the new medical school at Florida State University included \$50 million for a new facility with an annual operating budget of \$39 million, of which \$34 million (87 percent) would come from the state; the facility’s actual cost was around \$60 million.

A residency program, likewise, is not without costs, which were estimated in 2003 at about \$285,000 per resident. However, the same study estimated that each resident generated about \$246,000 in revenue, leaving an adjusted annual cost of only \$39,000 per resident.

The above numbers clearly show that building a new medical school requires an enormous initial investment with substantial capital up front as well considerable annual operating costs. At the same time, financing graduate medical education is not an inexpensive endeavor in and of itself with an annual cost in the ballpark of \$200,000 to \$300,000 per resident. Both require a significant fiscal commitment and the decision to finance one over the other must be carefully weighed.

We want to produce more physicians for our state. Don’t we need another medical school?

Building new medical schools and expanding residency programs both have the same outcome: more physicians. However, the type of physician and where the physician settles down and opens their practice are not pre-determined. A simple increase in the number of physicians does not necessarily automatically equal greater access to healthcare for those who need it most. The decision of which to finance should be made based upon which program can increase the overall access to healthcare in your state for those who need it most.

The strength of financing primary care GME is the ability of the residency program to tailor itself to the needs of the community. Medical schools are much larger than individual residency programs and tend to draw a high concentration of specialists and sub-specialists. For this reason, it is difficult to place medical schools in rural and/or

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We want to produce more physicians for our state. Don't we need another medical school?

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under-populated regions. Primary care residency programs tend to be smaller and more flexible in terms of location. Because of this, they can be established in rural, or less populated regions—often where increased access to healthcare is needed most.

For example, compare a rural, community-based **primary care** residency program to an urban, **tertiary-care** academic hospital. The level of access to healthcare that a primary care residency program can provide is much greater in comparison to a medical school. A 2000 study in the *New England Journal of Medicine* showed that less than one out of every one thousand people on average are hospitalized in an academic medical center whereas 113 of those thousand visit a primary care office in a given month (See Figure Below). Furthermore, the NIPDD report shows that community-based residency programs are almost \$150,000 less in annual cost per resident when compared to university-based programs.

Twenty-seven residency programs requested to the Residency Review Committee for Family Practice to withdraw voluntarily between 2000 and 2003. This marked a significant increase in program closure, heralding a corresponding decrease in the likelihood of many medical students selecting primary care. Financial issues were a major factor in all of the closures, leaving many community-based, non-profit and university hospitals, not to mention patients, in the lurch.¹

¹Gonzalez EH, Phillips RL Jr, Pugno PA. "A study of closure of family practice residency programs." *Fam Med*. 2003 Nov-Dec;35(10):706-10

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