Family practice and other primary care residency programs represent one of medical education’s most significant interfaces with public, social, and health care policy development. These training programs establish, by their number of residency positions, how many family physicians (or other primary care physicians) will be available in the future. They also determine, through the type and location of the residency positions, where those residents will practice after graduation and whether those graduated residents will help mitigate the nation’s health manpower shortage. Indeed, if one considers the huge amount of public money (mostly Medicare-related graduate medical education support) invested in family practice training programs, coupled with the programs’ roles in determining not only if citizens will have a physician to care for them but also what kind of physician will provide the care, our residencies assume a level of significance that deserves thoughtful consideration.

In the early 1970s, the Family Practice Residency Review Committee (FPRRC) and the first family practice residencies began to revolutionize medical education by moving the graduate education process out of teaching hospitals and into model outpatient practices. The eventual effect of this innovation was to begin the reversal of the trend toward “specialism” in medicine and to restore respect and credibility to the primary care disciplines. Thus, our residencies had taken the first steps as agents of public health care policy change.

Subsequently, it was found that residents tend to practice in the region and type of setting in which they train. One of the responses of family medicine educators to this finding was to locate family practice training programs in all 50 states and in multiple regions in many states. Again, the residency programs served as agents of change—this time in the attempt to spread the discipline across the United States and to increase the number of family physicians available to provide care for the US population.

As positive effects on the national shortage of primary care physicians were beginning to occur, and as the disparity between the number of graduating physicians entering specialty residencies versus those entering primary care programs finally began to shift, it became clear that there were still regions where physician shortages resisted correction. This situation existed even in the face of existing or predicted surpluses of physicians on a national scale. These regions tend to be rural and urban underserved areas.

Again, innovative family practice residency programs became change agents by developing training programs in these areas. Satellite programs of urban residences, often located in community health centers, were developed to address shortages of providers in urban underserved areas. Rurally oriented family medicine educators addressed rural physician shortages with rural training tracks (RTTs) and rural fellowships.

In this issue of *Family Medicine*, Rosenthal et al describe a systematic evaluation of 13 one- two rural residency tracks. Rosenthal et al note that 55% of the rural training sites are located in federally designated Health Professions Shortage Areas and that 76% of the graduates were placed in rural practices after completing their training. Also in this issue, Damos et al present a process for developing an RTT that should be useful to other programs considering the idea. Of special interest, Rosenthal notes that 75% of the RTT programs used televideo technology, and Damos mentions that videoconferencing, e-mail, Internet access, and computerized medical literature searches are useful components in the development of these off-site programs. If our discipline’s efforts to use high-tech educational modalities for urban and rural shortages are successful, this will be another example of family practice residencies serving as the tools for implementation of successful health care policy change.

The obvious question at this point is, “What next?” Has our experience of moving away from educational dependency on teaching hospitals, reversing the tide toward specialization, and assaulting...
the remaining pockets of physician shortage provided us with any knowledge that can be used to steer our future course? Undoubtedly, many directions could be considered, but let us look at two: 1) the trend of moving education into settings where education is not the raison d’être for the institution, and 2) the trend toward using televideo communications and other informatics technologies in medical education.

One of the major contributions to medical education made by family practice residencies has been to decentralize the educational process out of teaching hospitals, with their specialty and “exotic illness” focus, and into model family practice residency clinics and other community-based ambulatory care sites. The rural one-two programs have taken this decentralization one step further and moved it from the model residency clinics to rural family practice sites. This step may have several significant advantages.

First, most family practice residency clinics differ in significant ways from family practice clinics that are not residency sites. The most obvious difference is provider continuity. In residency programs, most faculty practice only 3–4 half days each week, and residents may practice there as little as 1–2 half days per week. Further, almost all of the residents leave the residency site after 3 years and are replaced by a new group. This discontinuity certainly influences both the makeup of the patient panel and the experience of the physicians caring for the patients. The other major difference between residency clinics and non-residency clinics is focus. The primary focus of a residency clinic is often (and probably correctly) on education, while patient satisfaction, continuity of care, access to one’s own physician, and meeting bottom-line financial expectations may be of secondary importance. In non-residency clinics, in contrast, the primary focus is not on education. One could argue that because more than 90% of the residency graduates will eventually

If the real world, immersion, and financial benefits of the RTT sites can be proven, then programmatically similar family medicine educational settings should be considered in urban (especially underserved) and suburban practices. Indeed, one can visualize residency programs consisting of only infrastructure, a faculty, and R1s at the central site, with the R2s and R3s being trained in “non-resident intense” practice settings, while receiving educational support from the central program. At a time when graduate medical education funds are under assault from balanced budget legislation, development of new models of training that are both educationally effective and cost effective would continue the tradition of positive change to which family practice training has contributed.

Another “what’s next?” for family medicine education must be in the area of biomedical informatics. In considering the RTT models of family practice residency training, both Rosenthal and Damos mentioned the roles of communications and computing. This is clearly another direction in which there are leadership and change-agent opportunities. As educational sites become more decentralized, long-distance communications among faculty, residents, administrators, specialists, and others will become increasingly important. We must learn how to apply videoconferencing and telemedicine technologies to these educational situations in ways that

It is quite difficult, without funds from outside sources (hospitals, state or federal governments, etc) to fund a family practice residency program. Perhaps the use of rural community-based sites that are not so highly “resident intensive” will be a less costly way to train family physicians.
add benefit. Further, it is clear that biomedical informatics will play an increasingly important role in the future of medicine. Whether discussing e-mail, computerized medical literature searches, electronic decision support algorithms, or computerized medical records, the graduates of our residencies will practice in an environment that is rich with information and will need competency in the use of the electronic tools to be effective in their future practices. These tools may allow us to improve the technical quality of our care, manage the information explosion, control costs, and improve the human side of our physician-patient interactions. If we can use our programs to supply the training in informatics that will be needed to approach these goals, we will be facilitators of positive change.

For the speech he planned to give in Dallas on November 22, 1963, President John F. Kennedy had written that, “Leadership and learning are indispensable to each other.” It seems appropriate that we use the knowledge gained through our past leadership to allow our training programs to continue to serve as positive agents for change in the interface between health care and public policy development.

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