

PRESIDENT'S COLUMN

Secrets of a Categorical Program Director— About Primary Care Residency Training

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I'm here to share the secrets of a categorical program director—about why you should want to train in a primary care residency program.



You are currently applying for an internal medicine residency position. You have probably applied to 10-12 programs and scheduled to interview through early January. In February, you must submit your rank list, and by March you will know where you will be spending the next three (3) years in training. This is both an exciting *and* a terrifying time. For some reason, trying to put down your choice of programs in exact order can be daunting. You are thinking about the reputation, the call schedule, the research time, maybe the quality improvement training. You wonder how supportive is the environment, whether the program director plans to stick around, and whether the chairperson is engaged in and supportive of education. Have you considered whether primary care training in a defined primary care program might be right for you?

I'm here to share the secrets of a categorical program director—about why you should want to train in a primary care residency track (no matter what part of internal medicine you seek to practice). In my career, I've been both a primary care program director and a categorical program director (at University of Pennsylvania [Penn] and Beth Israel Deaconess Medical Center [BIDMC], respectively). I have a unique perspective on the educational benefits from each form of training, having overseen both types of program (for three [3] years at Penn and for 13 years at BIDMC). I'm willing to tell you everything, all the secrets—risking the wrath of the "Program Director's Club." Here are the Top Ten

reasons that primary care (PC) training may be superior to categorical training in internal medicine for you:

1. *No matter what field of internal medicine you specialize in, you will (almost) all practice outpatient medicine.* From endocrinology to hematology/oncology and even to interventional cardiology, you will spend many hours each week seeing outpatients. A traditional categorical residency program simply doesn't give you enough "dwell" time in an outpatient practice to learn the skills necessary to manage an outpatient clinic's microsystem or to hone the office-based efficiency that you need for your future. Think about what percent of your clinical time will be spent in the outpatient setting if you become, let's say, an oncologist. Depending on your practice site, you will definitely spend more than half your clinical week seeing outpatients, and you may spend up to 100% of your clinical time in the outpatient, longitudinal management of your cohort of patients. What percent of categorical training is spent focusing on that practice setting? Not enough.
2. *Even if you don't practice outpatient medicine at all in your future career (so you become a hospitalist, or far less likely, a critical care attending), you will still benefit from primary care training.* First, your friends and family will, all their lives, expect

you to be able to give them advice and counsel (and often antibiotics) for their common medical problems. I'm only half-joking about that. But the real reason future hospitalists need to learn more outpatient medicine is that they will be discharging patients back to primary care providers (PCPs); I believe that the most effective hospitalists understand the extraordinary capabilities of most primary care doctors and practices. The best inpatient doctors need to have great communication skills with PCPs, respect for the patient centered medical home and their role in it, and be able to put themselves (and their patients) in the mindset of the PCP.

3. *The more inpatient time you do, the more time you spend on the same small number of total inpatient diagnoses that you encounter on the rotations the medical center needs you to staff.* How many "rule-out MI" admissions are of value to you? The number of medical problems you encounter in a PC continuity practice, or in enhanced ambulatory specialty electives, will keep you on the steep part of your learning curve. For example, in 2010, more than 1.2 million diagnoses were seen in ambulatory settings!¹ Your exposure to the range of internal medicine (and relevant non-medical specialty) diagnoses will be much broader in a PC program.

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4. *Primary care residents generally work fewer hours than categorical residents, when averaged over three years; they may also take fewer weekends of call.* That's not a good reason to choose a residency program, but it is true. However, fewer hours in the hospital does not translate into "easier." In the primary care programs that I've been associated with, the PC residents have much more project-based work—whether quality improvement projects, teaching preparation, or clinical follow-up between visits with patients. Many have told me they were surprised at how "hard" their PC tracks were in terms of hours of work beyond patient care and conferences. This work mimics their future responsibilities (or yours) as citizens of a practice environment—and prepares them to work in any ambulatory setting.
5. *Primary care practices are currently the locus of tremendous innovation in patient care delivery.* Because of the market forces of quality-based payment contracts and new forms of capitation, because of efforts to provide high-value care and to improve efficiency, and because of the fundamental challenges, including burnout, faced in traditional PC practices, many have undertaken exciting transformation to patient-centered medical homes and beyond. You want to train in an academic center that practices "cutting edge" medicine? Well the "cutting edge" is now found in primary care. What you learn there about innovation will serve you well no matter where you practice or what career you choose. Check out the list of innovative practices at the Primary Care Progress website to see some examples² or read SGIM member Chris Sinsky's work on high-functioning primary care practices.³
6. *Because more Americans have insurance, PC is now often more about health and less about dealing with financial challenges.* The Affordable Care Act has dramatically reduced the number of uninsured patients in the United States.⁴ The difference is palpable in my teaching practice—because most of the patients have coverage now, we can spend more of our time thinking about medical care and less struggling with coverage issues.
7. *Small programs are more nimble than big ones.* A categorical program can be an order of magnitude larger than a typical PC program. PC programs have the size advantage with more focused faculty attention on fewer residents, the ability to change curricula or rotation schedules quickly, and small group learning opportunities that are educationally sounder than larger lecture format sessions.
8. *Continuity clinic training in categorical programs has become quite discontinuous.* In 2009, the ACLGME's internal medicine program requirements were updated to require that "programs must develop models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities." That requirement led to the explosion of current "4+2" or "3+1" models that block out weeks specifically for inpatient-only (the bigger number) or outpatient-only rotations. While those models do fully avoid "conflicting inpatient and outpatient" schedules, they have made primary care learning very scattered, with many weeks possible between one practice session and the next. What can be lost is consistency, mentorship from a single preceptor, becoming embedded in the practice's microsystem, and close follow-up of patients who need to be seen before the next scheduled session (think new diabetic, asthmatic with exacerbation or pneumonia, heart failure patient in need of diuresis). With continuity practice a fact of life in most of the medical specialties, the clinical care of outpatients across time is a critical piece of education that has been marginalized in our current models.
9. *You will do just as well in the fellowship match from primary care training.* This is probably the biggest secret about primary care training—not only is it potentially better preparation for fellowship but also, at least in my experience as a categorical program director, you are just as likely to get one of your top choices of fellowship from a primary care track (assuming you pursue specialty-based research and mentorship during residency). Primary care program directors don't really want you to do a fellowship; they would prefer that their educational resources go toward future generalists. But if you are considering a specialty fellowship, a primary care program will not limit you.
10. *You might become a general internist—a primary care doctor or a hospitalist, a research-based, education-based, health-policy-based or QI-based leader.* The range of career options is incredibly wide in general internal medicine. Check it out through SGIM's Career Center and the ProudToBeGIM videos: www.proudtobeGIM.org.

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Through a PC residency program, you will be exposed to fantastic mentors doing a host of important, exciting, and innovative work. Maybe, just maybe, you will decide to put the PC track training to its intended use: to become a general internist.

If you do decide to apply to PC programs, be aware that they have become a pretty tough match over the past few years. Last year, there were 210 primary care internal medicine slots available through the match (up from 156 in 2010).⁵ The National Resident Matching Program (NRMP) reports that 99.3% of primary care spots were filled last year, with 60% filled by U.S. senior students compared to 98.8% and 46.9% for categorical internal medicine slots.⁶ I hope I have shown you a few of the reasons why there is increasing interest in primary care training.

Good luck with your interviews, rankings, and decisions. Talk with your trusted advisors—and ask about whether a primary care track might be best for you. I think it is!

Sincerely,
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President, Society of General Internal Medicine

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