

Training Primary Care Physicians to Serve Underserved Communities: Follow-up Survey of Primary Care Graduates

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descriptive statistics and analyzed and summarized the content of text iteratively by two readers (LA, ML).

Increasing proportions of primary care (PC) physicians enhance population life expectancy and quality of life.¹ Basu et al. found that “... as the density of primary care physicians decreased from 46.6 to 41.4 per 100, 000 population” mortality increased.² For the underserved, need for PCPs is higher, supply is worse, and attrition is greater due to burnout and leaving practice.³ Thus, effective training programs are necessary to prepare competent, committed, resilient doctors to practice PC, particularly with underserved communities.

Our prior, 2006, survey of 20 years of graduates from the NYU/Bellevue Primary Care Internal Medicine Residency (NYUBPC) concluded that program graduates’ high engagement in PC (over 90%) and unexpectedly low (15%) burnout relate to our program pillars: psychosocial medicine, clinical epidemiology, health policy, learning to learn and teach, being whole (patients and learners), and visioning—layered over rigorous inner-city clinical training.⁴

This report provides data on the subsequent 7 years of graduates to ascertain whether favorable outcomes persist in the new high-pressure primary care environment. We assessed the impact of NYUBPC on residents’ graduate career choices, values, and style and elicited reflections concerning complexities of educating primary care physicians.

METHODS

We sent an anonymous, web-based, 44-item, IRB-approved survey, including 12 open-ended questions about career path and reflections on residency training experiences, to all graduates (56) of the NYUBPC from 2007 to 2014. We summarized current practice and general perceptions of training with

RESULTS

We received 37/56 (66%) responses. Respondents averaged 5 years past residency (sd, 2.4). Eighty-nine percent practice PC. Seventy percent work with underserved populations. Eighty-five percent endorse PC as a career choice. Ninety-two percent agree or strongly agree their life is balanced. Six percent reported burnout. Seventy-four percent feel prepared for PC practice, rating as essential intense psychosocial medicine training, safety net hospital inpatient training, learning to teach and learn, and clinical epidemiology training (Table 1). Seventy percent of respondents have mentors. Personal connections with patients, peers and co-workers, and faculty were rated key. Open-text responses identify the program’s focus on the whole patient and its strong community support for trainees as essential to developing their skills and resilience against difficulties (see Table 2). Since graduating, alumni report struggling with the mismatch between the ideal PC they strive towards and the difficult pressures of time, productivity, and quality measures. They feel equally or more prepared for challenges of practice than colleagues trained elsewhere. While they anticipate an evolving PC landscape, they feel the program taught them essentials needed to adapt to changing circumstances.

DISCUSSION

While our graduates self-report that they are prepared for and committed to careers in PC for the underserved, they still suffer the slings and arrows of primary care today. In the rapidly evolving crunch of primary care needs and systems, our graduates recognized the challenges but felt equipped with skills and attitudes of resilient providers of primary care and educators.

Whereas mid-career doctors have the highest levels of “burnout” (53.9%), only 6% of ours reported burnout.⁵ We believe but cannot prove that our focus on longitudinally reinforced psychosocial training, a rigorous skills and clinical reasoning-focused curriculum, role modeling, care of the underserved, and strong social support from faculty and peers

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Table 1 Current Practice and Related Essential Training Experiences

	Percentage
Components of training considered essential to professional development (rating of 4 on 4-point Likert scale)	
Patient care in primary care setting	90%
Psychosocial medicine	83%
Inpatient training at city safety net hospital	83%
Resident-led conferences (with resident selecting topic)	73%
Learning to teach	65%
Clinical epidemiology	48%
Current practice (% endorsing each item)	
Practice in primary care setting	89
Average time per week spent in clinical work	66% (range, 0–100%)
Underserved patients in their practices	70%
Clinic atmosphere is hectic/chaotic (4 or 5 on 5-point Likert scale)	53%
Felt prepared for the challenges of primary care	74%
Agree or strongly agree with primary care as career choice (3 or 4 on 4-point Likert scale)	85%
Agree or strongly agree that their “life is balanced” (3 or 4 on a 4-point Likert scale)	92%
Report persistent symptoms of burnout (4 or 5 on a 5-point Likert scale)	6%

provides our trainees with the resilience required in under resourced systems with underserved communities. However, as 44% did not respond, they may be struggling more or less resilient.

Training program transformations are necessary but not sufficient components of the complex changes needed to ensure well-prepared PC doctors join and stay in practice in high-need communities. Indeed, our residents report challenges to purity of practice, continuity of care, and opportunities for advocacy. As our country faces a debilitating shortage of PC doctors, a multifaceted approach to supporting their professional development and success is paramount. Programs must evolve to ensure that residents have essential skills for doctors and systems to thrive in a challenging health care environment.

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Compliance with Ethical Standards:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

REFERENCES

1. **Starfield B, Shi L, Macinko J.** Contribution of primary care to health systems and health. *The Milbank quarterly.* 2005;83(3):457–502. <https://doi.org/10.1111/j.1468-0009.2005.00409.x>
2. **Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS.** Association of Primary Care Physician Supply With Population Mortality in the United States, 2005–2015. *Association of US Primary Care Physician Supply and Population Mortality Association of US Primary Care Physician*

Table 2 Open-ended Responses About Impact of Training on Current Practice

Theme	Resident quotes
Residency shapes complex understanding of patient need	<ul style="list-style-type: none"> • “My training allowed me to be compassionate, understanding of multicultural aspect of patient care. In my current position, there are mixed ethnicities, first and second-generation immigrants “ • “Psychosocial rounds dramatically changed my ability to sympathize/empathize/connect to patients and situations. I am able to channel a calmness that is often elusive in other parts of my life and for other clinicians when faced with a difficult situation for patients.” • “The insistence that all of my patients be viewed as people, ability to meet with a “difficult patient” and see a challenge and an opportunity rather than a hassle, and insistence that the education of our residents is as important as anything else that we do. I try to bring this to the teaching that I do currently.” • “The time that we spent during our PC blocks doing research, learning to lobby, and thinking about psychosocial contributors to health were very unique. My preparation as a well-rounded physician meant for vastly different interactions with my patients, their families, and my interns throughout my years.”
Challenges to patient-centered care	<ul style="list-style-type: none"> • “It imbued me with values and ideals, more than anything: care of the patient, especially those poor and disadvantaged; a healthy skepticism for and admiration of medical evidence.” • “The advocacy/policy part is something I would aspire to do but as a young clinician-educator it is hard to incorporate” • “Continuity of care - this has become more difficult to achieve as our health care system evolves, especially in major metropolitan areas.” • “Maintaining a “purity” of primary care practice - not influenced by time pressures, reimbursements, metric achievements, and politics”
Preparedness of practice	<ul style="list-style-type: none"> • “In retrospect, I think I was just as prepared as they were, although I think my confidence could have been a little better.” • “I think I had a better approach to difficult patients and somatizing patients than my colleagues” • “While I feel that the PC residency prepared me ideologically for primary care, I am not sure that it prepared me to make a decision about what type of primary care I might practice.” • “I think that we did not have enough exposure to electives - particularly sub-specialties of internal medicine that would be helpful as a general internist” • “Delegating tasks and coordinating information - it was hard to be viewed as team leader early in my career”

- Supply and Population Mortality. JAMA Internal Medicine. 2019;179(4):506–14. <https://doi.org/10.1001/jamainternmed.2018.7624>
3. **Zabar S, Wallach A, Kalet A.** The Future of Primary Care in the United States Depends on Payment ReformThe Future of US Primary Care Depends on Payment ReformResearch. JAMA Internal Medicine. 2019;179(4):515–6. <https://doi.org/10.1001/jamainternmed.2018.7623>
 4. **Lipkin M, Zabar SR, Kalet AL, Laponis R, Kachur E, Anderson M,** et al. Two decades of Title VII support of a primary care residency: process and outcomes. Acad Med. 2008;83(11):1064–70. <https://doi.org/10.1097/ACM.0b013e31818928ab>
 5. **Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD.** Physician Satisfaction and Burnout at Different Career Stages. Mayo Clinic Proceedings. 2013;88(12):1358–67. <https://doi.org/10.1016/j.mayocp.2013.07.016>

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