Implementing the patient-centered medical home is not enough to improve health care quality; physician education also needs to change, emphasizing team-based approaches to care, participants said at a summit to discuss training gaps in primary care, behavioral health care, and health promotion.

“The summit, held at the Carter Center in Atlanta, examined whether medical students are being trained appropriately to function effectively in the newly reformed health care environment. “Purchasers are actively choosing to buy different kinds of care” because they can’t find the types they need in the current system, said Dr. John Bartlett, senior adviser for the Primary Care Initiative at the Carter Center. “Private purchasers are getting tired of paying the price of poor-quality medical education,” Dr. Bartlett told reporters in a conference call.

Meeting participants identified several key deficits in the U.S. medical education system, according to Dr. Michael Barr, senior vice president for medical practice, professionalism, and quality at the American College of Physicians. “We train people separately and expect them to work together,” Dr. Barr said. And in many programs, physicians-in-training don’t meet actual patients until relatively late in their training. Many curriculum don’t emphasize the types of mental health issues that primary care physicians will need to practice, he added.

Some medical schools have programs worth emulating, but large-scale implementation might require changes in accreditation and regulatory requirements, Dr. Barr said. For example, the University of Wisconsin introduces medical students to patients on their first day in class, which helps sensitize students early in medical education, said Dr. Jeffrey N. Katz, on the correlation between the age at hip replacement and risk for revision, page 32.

Dr. Barr pointed out several changes in medical education that could be implemented relatively quickly:
- Providing more training for medical students with nonphysician mental health professionals.
- Emphasizing wellness and prevention.
- Developing faculty members who can teach within the patient-centered medical home model of care.

Dr. Barr also noted that redesigning health education could help prevent discouragement among medical students who already were interested in a primary care career, but who become disillusioned during medical school. “Among the several factors that influence their eventual choices is the lack of available role models who provide patient-centered primary health care based on the medical home model,” he said in an interview.

However, both Dr. Barr and Dr. Bartlett noted that improving medical education won’t solve the shortage of primary care physicians unless reimbursement is also addressed.

“Improving education is an important step, but we also need to incentivize more physicians to pursue primary care,” Dr. Barr said, noting that currently, only 10% of medical students choose primary care residencies.

“We do have to talk about reimbursements and other financial rewards for choosing primary care,” Dr. Barr said in an interview. “I’d especially like to see more funding for researching best practices of incorporating behavioral health into primary care, since we know that between half and 70% of patients seen by primary care doctors have some kind of behavioral health component to their care, and physicians simply aren’t equipped to effectively and efficiently deal with these mental health issues.”

VERBATIM

As total hip replacement indications extend to increasingly younger populations, [the patients’] mortality risk will diminish, and a vast majority will remain at risk for revision for decades.’

Dr. Jeffrey N. Katz, on the correlation between the age at hip replacement and risk for revision, page 32.