In Response to “Disparities in Quality of Primary Care by Resident and Staff Physicians: Is There a Conflict Between Training and Equity?”

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In “Disparities in Quality of Primary Care by Resident and Staff Physicians: Is There a Conflict Between Training and Equity?,” Essien et al. suggest quality of care provided by internal medicine residents was lower than that by faculty in the same settings.¹ However, this well-done evaluation of study sites does not appear to be applicable to all residency sites. One week prior, Edwards et al. published a research letter comparing quality of outpatient care between residents and faculty at Veterans Affairs (VA)–based clinics with a different conclusion: quality and utilization were comparable.²

Why such different outcomes from two contemporary, robust evaluations? In both studies, resident panels had more medically and socially complex patients. Even with appropriate adjustments, there can be some residual confounding of differences which may explain some findings. Perhaps more important are the context and continuity in which clinical care is provided. The health system, ambulatory clinic, and training schedule define important factors for quality, trainee experience, and patient satisfaction. In 2010, the VA embarked on a system-wide transformation to the Patient-Centered Medical Home model supporting more effective outpatient infrastructure.³ Along with this transformation, the VA Office of Academic Affiliations created interprofessional primary care training by implementing seven “Centers of Excellence in Primary Care Education” (CoEPCE), requiring at least 30% of training in VA primary care for participating internal medicine residents.⁴ These sites supported trainee-team-patient continuity using novel clinic schedules. Learners were also trained in collaborative practice, using

innovative workplace learning strategies to support team huddles, interprofessional hand-offs, population health management, and case conferences for high-risk patients. Half the clinic sites in the Edwards study were CoEPCE sites; this may have improved quality, but the study did not specifically test this hypothesis. Continuity is perhaps an even more important missing variable. Generally, continuity in resident clinics is lower than faculty practices, but evidence-based methods to maximize continuity exist.⁵ Examining levels of continuity between quartiles of high-performing and low-performing providers, as well as continuity with the larger clinic team, might help to explain findings.

The Essien study states “...novel approaches are needed to address residency ambulatory medical education, a central issue to improving overall quality and equity of primary care.” We suggest examining continuity levels as well as lessons learned in the VA and CoEPCE to maximize proactive team-based could help to give specific examples on how to improve quality of care in training clinics.

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Compliance with Ethical Standards:

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

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