Expressed Reasons for the Choice of a Residency in Family Practice

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An analysis was conducted of expressed reasons for the choice of a family practice residency by prospective residents. The nature and frequency of reasons are presented. An attempt was also made to judge the importance or saliency of specific reasons expressed. The results are discussed in relation to past studies and future directions for the training of family physicians.

That an individual's psychological and behavioral characteristics may have important implications for competence, enjoyment, and ultimate success in the field of medicine, as well as influencing overall quality of care and directions in training, has no doubt been the justification for the proliferation of psychological studies of medical personnel.[1-6] The logical extension of assessing the characteristics of physicians in general has been to look for specific characteristics of medical specialists and attitudes towards specialties and specialists in a variety of populations.[7-11]

As a new specialty, studies on the psychological parameters unique to family practice seem to be sparse. Studies which assessed characteristics of the general practitioner are available, although these data are often part of a larger investigation, and are generally now antiquated.[7-9,11-14] Studies on characteristics of those individuals electing family practice as a specialty are beginning to emerge, however. Quenk and Heffron[15] administered an objective psychological test to family practice residents "volunteered" by their program directors. According to their study, family practice residents are practical, realistic, organized, and able to deal effectively with factual information. The authors also found differences in interactive and personal styles between the "teachers" of family medicine and their "students" which suggest both a difficulty and direction for didactics and supervision in residency training programs. Collins and Roessler[16] compared the characteristics of third and fourth year medical students choosing one of the five specialties including family practice. Family practice selectors were found in general to be more affiliative, less aggressive, and less materialistic than students selecting other specialties. Cullison, Reid, and Colwill[17] found that physicians entering family practice were three times as likely to select a nonmetropolitan practice as physicians in other primary care specialties. It was also found that a combination of the characteristics of a nonmetropolitan background and the selection of a family practice specialty accounted for two thirds of those physicians electing to practice in a nonmetropolitan setting.

Such studies while useful as preliminary data exhibit several shortcomings, including small sample size[16] and potentially biased or undeter-

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Table 1. Distribution of Residency Applicants by State

State	Number
Pennsylvania	35
New York	17
Maryland	7
Vermont	4
Virginia	4
West Virginia	4
Connecticut	2
District of Columbia	2
Iowa	2
Michigan	2
Georgia	1
Kansas	1
Missouri	1
North Carolina	1
Ohio	1
Rhode Island	1
South Carolina	1
Texas	1
Mexico	1
Total	88

minable sample characteristics.[15-17] Further, it is interesting and surprising that in the rush to "psychologize" the selection of family practice residents, no one has apparently employed the most basic technique of self-report: asking the candidates why they desired to enter family practice.

The expressed reasons for the choice of family practice take on particular significance in light of two findings by Bruhn and Parsons.[7] In their study it was found that students planning to enter a particular specialty emphasize the positive traits of their specialty, and further, that despite this particular emphasis, their stereotypes of the specialty did not differ greatly from students not choosing that specialty. Secondly, the authors reported that students saw themselves possessing many of the traits which they ascribed to specialists in their chosen field. Thus, there is reason to believe that the expressed reasons for choosing family practice as a residency reflect not only the image of the specialty but also a view of how students see themselves in relation to it. Therefore, this paper presents a study of expressed reasons for the choice of family practice as a specialty.

Method

Data were compiled from 88 fourth year medical students applying for residency training in family practice at Harrisburg Hospital, Harrisburg, Pennsylvania for the year 1977. Harrisburg Hospital is a 450-bed community hospital affiliated with the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, with a four-year-old approved Family Practice Residency Program and a total of 18 residents.

As part of the interview process in the selection of residents, all candidates who actually came for an interview were requested to complete an information sheet, eliciting the following information: (1) Briefly describe your interest in and commitment to family practice; (2) What do you expect from a family practice residency; (3) What type of practice is your goal and where; (4) Why are you applying to this residency program. These sheets then served as a source of information as to the nature and frequency of expressed reasons for the choice of a family practice residency. Rankings of the saliency or importance of the reasons were derived somewhat arbitrarily by assigning a numerical rating to each reason in order as written on the information sheet. Thus, the first reason given for the choice of family practice as a specialty was assigned a "1" and each additional reason on the given sheet a subsequent numerical rating. The assumption behind this procedure was that prospective residents, especially in the interview situation, would express first, unless otherwise stated, those reasons most important to them for the choice of specialty, or those reasons which they perceived would be most important and impressive to others in the interviewing situation. Ratings for a given reason were then averaged to obtain an average rating.

Results

The results of this study were compiled from 76 male and 12 female prospective residents. The interviewees, while coming predominantly from the Middle Atlantic states, do represent a sampling of other geographic regions and various medical schools. The exact geographical representation is presented in Table 1.

The nature and frequency of expressed reasons for a family practice residency are summarized in Table 2.

The predominant reason for the selection of family practice was a preference to treat the patient as a person, to treat the whole person (N = 47). This was expressed by over half of the applicants. A preference for primary care was the second most frequently reported reason (N = 22) expressed by applicants. The preference to do comprehensive care and the preference to treat a variety of illnesses were both offered by approximately one quarter of the prospective residents (N = 20). The requirements of practice dictated by the desired geographical location, that is, the demands of rural practice entered into the decision process for 19 percent of the applicants (N = 17). The remaining reasons expressed by a sizable number of applicants in descending order of frequency were: response to the problem of medical manpower needs, 14 percent (N = 13); the influence of an academic role model or other academic experience with family medicine, 14 percent (N = 12); the preference to treat a variety of age groups, 14 percent (N = 12), and the influence of a nonacademic role model, 12 percent (N = 10).

The mean rankings of the expressed reasons for specialty choice, while not demonstrating great variation, did provide a rank order as indicated in Table 3.

The reason receiving the highest mean rating of order of presentation was the influence of a nonacademic role model ($\bar{x}$ = 1.30). Preference to treat the whole person was given the second highest mean rating ($\bar{x}$ = 1.49). Influence of an academic role model or other academic experience in a family practice setting received the next highest mean rating of order of presentation ($\bar{x}$ = 1.50). The preference for primary care and the desire to meet manpower needs received equivalent ratings ($\bar{x}$ = 1.62). The remainder of the expressed reasons in descending rank order were: requirements of location ($\bar{x}$ = 1.71); preference to treat a variety of illnesses ($\bar{x}$ = 1.80); preference to do comprehensive care ($\bar{x}$ = 2.10), and preference to see a variety of age groups ($\bar{x}$ = 2.33).

Discussion

This survey revealed nine predominant, expressed reasons for the choice of a family practice residency by prospective residents. Importantly, all nine reasons either appropriately define the basic tenets and goals of family medicine or fit with the realities of such a practice. There may be some speculation raised as to whether these responses represent the true interest of the applicants or are merely an attempt to give reasons important and pleasing to the interviewing institution. This question cannot be answered in this study, but may actually be of secondary importance. The more important issue appears to be that the nature of family practice has been transmitted and is being correctly perceived by those apparently interested in pursuing the specialty. Further, if the findings of Bruhn and Parsons[7] cited earlier are relevant, it may be more safely concluded that there is a basic congruence between the goals of family medicine and these applicants.

Table 2. Frequency of Expressed Reasons for Selection of a Family Practice Residency

Reason	N	%
Preference to treat the 'whole' person	47	53
Preference to do primary care	22	25
Preference to do comprehensive care	20	23
Preference to treat a variety of illnesses	20	23
Requirements of location	17	19
Desire to meet manpower needs	13	14
Influence of academic role model or other experience in family practice setting	12	14
Preference to see a variety of age groups	12	14
Influence of nonacademic role model	10	12

It is instructive to compare the expressed reasons for specialty choice in this study with other studies of this nature, for the present population does certainly have its biases (ie, Eastern United States, nonuniversity setting, etc). Unfortunately, no other comparable studies apparently exist except for that of Monk and Terris[12] done on general practitioners nearly 23 years ago. Such a longitudinal comparison may be as fruitful as an horizontal comparison, however, in highlighting some of

Table 3. Mean Rankings of Expressed Reasons for Selection of a Family Practice Residency

Reason	Mean Rank
Influence of nonacademic role model	1.30
Preferring to treat the 'whole' person	1.49
Influence of academic role model or other experience in family practice setting	1.5
Preference for primary care	1.62
Desire to meet manpower needs	1.62
Requirements of location	1.71
Preference to treat a variety of illnesses	1.80
Preference to do comprehensive care	2.10
Preference to see a variety of age groups	2.33

the changes and similarities shared by family medicine and its parental forerunner.

The most obvious enduring trait seemingly unchanged from the earlier study is concern for the patient-physician relationship and the treatment of the person as a total entity. In both the study reported by Monk and Terris[12] two decades ago and the present study, the implications for humanism in medicine are clear. However, while the predominant reason in the present study for the choice of family practice was the desire to treat the patient as a whole; this was the secondary reason given in the Monk and Terris study. In that study, the desire to treat a variety of illnesses was given most frequently as a choice for doing general practice, while in the present study factors which make up this category seem to have fallen to the fourth and eighth position among reasons listed.

Another enduring characteristic is also evidenced. This is the choice of family practice as a necessity if the goal is a rural geographic location. Indeed, Cullison et al[17] reported family physicians are three times as likely as other primary care physicians to engage in a rural practice.

Several reasons for the selection of general practice as reported by Monk and Terris have dropped out or were not mentioned in the present study. Reported as additional expressed reasons for the choice of general practice over another specialty were the following: "desire to enter practice sooner," "don't want to spend rest of my life in training," "inability to afford financing of a residency." That these reasons do not appear among the present group of prospective residents is probably indicative of the changing nature of family practice and family practice residencies compared with general practice, and the kind of motivation of students who are currently selecting family practice as opposed to those students entering general practice two decades ago.[12,13,16]

A variety of reasons not relevant to the major characteristics listed did emerge in this survey. Their disparate nature indicates that while a general consensus does appear to exist for entry into family practice, there are also many idiosyncratic reasons for this specialty choice. Other reasons offered included the following: "the challenge, interest, and satisfaction of family practice, the opportunity to work independently, the high level of esteem accorded the family physician by the community, the chance to participate in the life of the community, a dislike of university medicine, the opportunity to do patient education, the opportunity to do mental health counseling, the effects of family upbringing, seeing family practice as a solution to some of the problems of modern medicine, the fact that family medicine needs good people, the desire to do quick treatment, the desire to do missionary medicine, and Christian love."

A further relevant finding, apparent from Tables 2 and 3, is that the rank ordering of expressed reasons for the choice of a family practice specialty differs considerably depending upon whether the ranking is based on the frequency of expressed reasons (Table 2) or the order of expression of reasons (Table 3). A most basic conclusion, however, remains the importance of the desire to treat the whole person, as a factor in the selection of family practice as a specialty. Whatever the method of ranking, this reason assumes a first or second position. Taken with its historical precedent it seems safe to conclude that this is truly the hallmark of family practice.

The difference in the rank orders does indicate, however, that even though a particular reason may be expressed with some great frequency, it is not necessarily of equal salience or importance to an individual. Of particular significance, then, is the finding that when ranking according to primacy or order of expression, the effect of role models (either nonacademic or academic) is a powerful influence on some individuals to enter family practice. It is particularly significant that it is the influence of a nonacademic role model (which generally means experience with one's own family physician) that seems to have the greatest impact. It is, therefore, most interesting that despite the intellectualized reasons for the need for family practice (manpower needs, primary care, etc), it is the simple behavior of the family physician himself, his/her role modeling, that is of such great influence in "recruiting" future family physicians. This would seem to place a great responsibility on each individual family physician to guide the direction and nature of this specialty by virtue of his/her role modeling. This should not be surprising, however, for the data seem to bear out the intuitive feedback loop that recognition and treatment of a person as a person are an impressive impetus to emulation.

Conclusion

This study attempts to define the most frequently expressed reasons for fourth year medical students' selection of family practice as a specialty. Some concerns about terminology arose. Certainly the terms "comprehensive care," "primary care," and "whole person" can mean different things to different persons. No correlation between the applicant's medical school and the applicant's stated reasons for selecting family practice was made. It may well be that certain terminologies are common to the persons providing interview information or techniques to fourth year medical students in that school. A preponderance of applicants from these schools could influence the statistics. Secondly, applicants to family practice residency programs are often coached by faculty and publications not only to seek certain information, but also to identify the strengths of family practice as a specialty. Some of these are caring for the "whole family," treating a variety of ages and disorders, and being the "primary" physician for their health care.

It is impressive that family physician role models outside the medical school and family practice faculty in the school ranked so strongly as determining figures. Secondly, it is noteworthy that patients' need for care, area medical needs, and physician locations were frequently offered as reasons for family practice specialty training. Thirdly, it is noteworthy that financial goals, social needs, and professional rewards were not mentioned.

These findings suggest the need to examine critically the methodology of student selection if there is to be a greater number of family physicians provided by medical schools.

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